

State: Hawaii

Agency*	Citation(s)	Groups Covered
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**A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)**

**2. Deemed Recipients of AFDC**

1902 (a)(10)(A)(i)(I)  
of the Act

b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individual) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482 (e)(6) of the Act.

482 (a)(22)(A)  
of the Act

c. Individuals whose AFDC payment are reduced to zero by reason of recovery of overpayment of AFDC funds.

406(h) and  
1902(a)(10)(A)  
(i)(I) of the Act

d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.

1902(a) of  
the Act

e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

\* See Supplement 15 to Attachment 2.6-A for eligibility under section 1931 of the Act.

\* Agency that determines eligibility for coverage.

TN No. 97-003  
Supersedes  
TN No. 91-21

Approved Date MAY 1 6 1990

Effective Date JUL 1 1991

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

ATTACHMENT 2.2-A  
Page 2a  
OMB NO.: 0938-

State: HAWAII

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

407(b), 1902  
(a)(10)(A)(1)  
and 1905(m)(1)  
of the Act

3. Qualified Family Members

Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed.

Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.

1902(a)(52)  
and 1925 of  
the Act

4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)

\*Agency that determines eligibility for coverage.

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TN No. <u>91-21</u>	Approval Date <u>10/13/92</u>	Effective Date <u>10/01/91</u>
Supersedes		
TN No. <u>88-15</u>		HCFA ID: 7983E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)

Groups Covered

A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

1902(a)(10)  
(A)(i)(V) and  
1905(m) of the  
Act

Duplicates item A.3  
on page 2a,  
per MRM 92-10. *ckw*

1902(e)(5)  
of the Act

1902(e)(6)  
of the Act

~~10. Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.~~

11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.

b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

TN No. 92-15

Supersedes

TN No. 88-16

Approval Date 10/29/92

Effective Date 7/1/92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1902(e)(4)  
of the Act

12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.

42 CFR 435.120

13. Aged, Blind and Disabled Individuals Receiving Cash Assistance

a. Individuals receiving SSI.

This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.

           Aged

           Blind

           Disabled

\*Agency that determines eligibility for coverage.

TN No. 00-006

Supersedes

TN No. 88-16

Approval Date: JUL 11 2000

Effective Date: APR 1 2000

HCFA ID: 7983E

State: \_\_\_\_\_

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.120

13.  b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

Aged

Blind

Disabled

The more restrictive categorical eligibility criteria are described below:

\* Definition of disability as defined in 42 C.F.R. 435.540 and 435.541

\* Definition of blindness as defined in 42 C.F.R. 435.530 and 435.531

(Financial criteria are described in ATTACHMENT 2.6-A).

\*Agency that determines eligibility for coverage.

TN No. 01-011

Supersedes

TN No. 00-006

Approval Date: DEC 20 2001

Effective Date: OCT 1 2001

HCFA ID: 7983E

State: HAWAII

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1902(a)  
(10)(A)  
(i)(II)  
and 1905  
off(q) of  
the Act

14. Qualified severely impaired blind and disabled individuals under age 65, who - -
- a. For the month preceding the first month of (q) eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or
  - b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must - -
    - (1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;
    - (2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;
    - (3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

\*Agency that determines eligibility for coverage.

TN No. 00-006

Supersedes

TN No. 86-16

Approval Date: JUL 11 2000

Effective Date: ADD 1 2000

HCFA ID: 7983E

State: HAWAII

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

- (4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and
  - (5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant services that would be available if he or she did have such earnings.
- Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

\*Agency that determines eligibility for coverage.

TN No. 00-006  
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TN No. 86-16

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AUGUST 1991

ATTACHMENT 2.2-A  
Page 6d  
OMB NO.: 0938-

State: HAWAII

Agency\* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

1619(b)(3)  
of the Act ;

X

The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

\*Agency that determines eligibility for coverage.

TN No. 91-21  
Supersedes  
TN No. \_\_\_\_\_

Approval Date 10/13/92

Effective Date 10/01/91

HCFA ID: 7983E



State: HAWAII

Agency*	Citation(s)	Groups Covered
		<b>A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u></b>
1634(c) of the Act		15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who-- <ul style="list-style-type: none"><li>a. Are at least 18 years of age;</li><li>b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.</li><li><input checked="" type="checkbox"/> c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.</li><li><input type="checkbox"/> d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.</li></ul>
42 CFR 435.122	16.	Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.
42 CFR 435.130	17.	Individuals receiving mandatory State supplement

\*Agency that determines eligibility for coverage.

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Supersedes  
TN No. \_\_\_\_\_ HCFA ID: 7983E

State: HAWAII

Agency\*      Citation(s)      Groups Covered

A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

42 CFR 435.131

18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.

In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

Aged       Blind       Disabled

Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

\*Agency that determines eligibility for coverage.

TN No. 91-21  
Supersedes  
TN No. \_\_\_\_\_

Approval Date 10/13/92

Effective Date 10/01/92

HCFA ID: 7983E

State: HAWAII

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

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|----------------|-----|--|
| 42 CFR 435.132 | 19. | Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they--<br><ul style="list-style-type: none"><li>a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and</li><li>b. Remain institutionalized; and</li><li>c. Continue to need institutional care.</li></ul> |
| 42 CFR 435.133 | 20. | Blind and disabled individuals who--<br><ul style="list-style-type: none"><li>a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and</li><li>b. Were eligible for Medicaid in December 1973 as blind or disabled; and</li><li>c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.</li></ul>   |

\*Agency that determines eligibility for coverage.

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TN No. <u>91-21</u>	Approval Date <u>10/13/92</u>	Effective Date <u>10/01/91</u>
Supersedes		HCFA ID: 7983E
TN No. _____		

State: HAWAII

Agency\* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.134

21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

\*Agency that determines eligibility for coverage.

TN No. 91-21 Approval Date 10/13/92 Effective Date 10/01/91  
Supersedes  
TN No. 88-16 HCFA ID: 7983E

State: HAWAII

Agency\*      Citation(s)      Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.135

22. Individuals who --

- a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and
- b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.

Not applicable because the State applies more restrictive eligibility requirements than those under SSI.

The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

\*Agency that determines eligibility for coverage.

TN No. 91-21  
Supersedes  
TN No. 87-17

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Effective Date 10/01/91

HCFA ID: 7983E

State: HAWAII

Agency\* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

1634 of the  
Act

23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.

Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

\*Agency that determines eligibility for coverage.

TN No. 91-21  
Supersedes  
TN No. 89-7

Approval Date 10/13/92

Effective Date 10/01/91

HCFA ID: 7983E

State/Territory: HAWAII

Agency\* Citation(s) Groups Covered

1634(d) of the Act

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.

\_\_\_\_\_ The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.

X In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in § 1634(d)(1)(A) in determining the income of the individual but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.

\_\_\_\_\_ In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in § 1634(d)(1)(A) in determining the income of the individual which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to be disregarded is specified in Supplement 4 to Attachment 2.6-A.

\_\_\_\_\_ In determining eligibility as categorically needy, the State chooses not to deduct any of the benefits identified in § 1634(d)(1)(A) in determining the income of the individual

\*Agency that determines eligibility for coverage.

TN No. 91-21  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

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State: HAWAII

Agency*	Citation(s)	Groups Covered
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**A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)**

1902(a)(10)(E)(i)  
and 1905(p) of  
the Act

**25. Qualified Medicare beneficiaries--**

- a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act);
- b. Whose income does not exceed 100 percent of the Federal poverty level; and
- c. Whose resources do not exceed twice the maximum standard under SSI.

(Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)

1902(a)(10)(E)(ii),  
1905(s) and  
1905(p)(3)(A)(i)  
of the Act

**26. Qualified disabled and working individuals--**

- a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act;
- b. Whose income does not exceed 200 percent of the Federal poverty level; and
- c. Whose resources do not exceed twice the maximum standard under SSI.
- d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.

(Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)

\*Agency that determines eligibility for coverage.

No. <u>93-03</u>	Approval Date <u>5/3/93</u>	Effective Date <u>1/1/93</u>	TN
Supersedes			
TN No. <u>91-21</u>			



State: HAWAII

Agency*	Citation(s)	Groups Covered
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**A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)**

1902(a)(10)(E)(iii)  
and 1905(p)(3)(A)(ii)  
of the Act

**27. Specified low-income Medicare beneficiaries--**

- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);
- b. Whose income for calendar years 1993 and 1994 exceeds the income level in 25. b., but is less than 110 percent of the Federal poverty level, and whose income for calendar years beginning 1995 is less than 120 percent of the Federal poverty level; and
- c. Whose resources do not exceed twice the maximum standard under SSI.

(Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)

\*Agency that determines eligibility for coverage.

No. <u>93-03</u>	TN	
Supersedes <u>91-21</u>	Approval Date <u>5/3/93</u>	Effective Date <u>1/1/93</u>
TN No. _____		

Agency*	Citation(s)	Groups Covered
		<b>A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u></b>
	1634(e) of the Act	28. a. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) or (v) of Section 1611(e)(3)(A) shall be treated, for purposes of title XIX, as receiving SSI benefits for the month.  <u>X</u> b. The State applies more restrictive eligibility standards than those under SSI.  Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of clause (i) or (v) of Section 1611(e)(3)(A), and who continue to meet the more restrictive requirements for Medicaid eligibility under the State plan, are eligible for Medicaid as categorically needy.

\*Agency that determines eligibility for coverage.

TN No. 96-006  
Supersedes 95-001 Approval Date 6/20/96 Effective Date 2/1/96  
TN No. 95-001

State: HAWAII

Agency\*      Citation(s)      Groups Covered

**B. Optional Groups Other Than the Medically Needy**

42 CFR  1. Individuals described below who meet the  
435.210      1902(a)      income and resource requirements of AFDC, SSI, or an  
(10)(A)(ii) and      optional State supplement as specified in 42  
1905(a) of      CFR 435.230, but who do not receive cash  
the Act      assistance.

The plan covers all individuals as described above.

The plan covers only the following group or groups of individuals:

- Aged
- Blind
- Disabled
- Caretaker relatives
- Pregnant women

42 CFR  2. Individuals who would be eligible for AFDC, SSI  
435.211      or an optional State supplement as specified in 42  
CFR 435.230, if they were not in a medical institution.

\*Agency that determines eligibility for coverage.

TN No. 91-21      Approval Date 10/13/92      Effective Date 10/01/91  
Supersedes  
TN No. 89-07      -      HCFA ID: 7983E

State: HAWAII

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.212 &  
1902(e)(2) of the  
Act, P.L. 99-272  
(section 9517) P.L.  
101-508 (section  
4732)

3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

The State elects not to guarantee eligibility.

The State elects to guarantee eligibility. The minimum enrollment period is \_\_\_\_\_ months (not to exceed six).

The State measures the minimum enrollment period from:

The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.

The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

\* Agency that determines eligibility for coverage.

TN No. 03-003

Supersedes 1

TN No. 97-21

Approval Date: MAR 2 2004

Effective Date: AUG 13 2004

State: HAWAII

Agency*	Citation(s)	Groups Covered
1932(a)(4) of the Act B.	<u>Optional Groups Other Than the Medically Needy</u> (Continued)	

The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

X Disenrollment rights are restricted for a period of 12 months (not to exceed 12 months).

During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

       No restrictions upon disenrollment rights.

1903(m)(2)(H),  
1902(a)(52) of the  
Act  
P.L. 101-508  
42 CFR 438.56(g)

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

X The agency elects to provide automatic reenrollment of the above individuals into the same entity if they were disenrolled solely because of loss of Medicaid eligibility for a period of 2 months or less.

       The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

\* Agency that determines eligibility for coverage.

TN No. 03-003  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

Approval Date: MAR 2 2004 Effective Date: AUG 13 2003

State: HAWAII

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.217

4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

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TN No. 05-011

Supersedes

TN No. 03-003

Approval Date: MAR - 6 2006 Effective Date: 10/01/05

State: HAWAII

Agency\* Citation(s) Groups Covered

**B. Optional Groups Other Than the Medically Needy**  
(Continued)

1902(a)(10)  
(A)(ii)(VII)  
of the Act

5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

The State covers all individuals as described above.

The State covers only the following group or groups of individuals:

- Aged
- Blind
- Disabled
- Individuals under the age of--
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women

Agency that determines eligibility for coverage.

TN No. 91-21 Approval Date 10/13/92 Effective Date 10/01/91  
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State: HAWAII

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Agency*	Citation(s)	Groups Covered
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**B. Optional Groups Other Than the Medically Needy**  
(Continued)

42 CFR 435.230

10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in the State.
- d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.
  - \_\_\_ (1) All aged individuals.
  - \_\_\_ (2) All blind individuals.
  - \_\_\_ (3) All disabled individuals.

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TN No. 91-21  
Supersedes  
TN No. 89-2

Approval Date 10/13/92

Effective Date 10/01/91

HCFA ID: 7983E



State: HAWAII

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Agency*	Citation(s)	Groups Covered
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**B. Optional Groups Other Than the Medically Needy**  
(Continued)

- |                |     |   |
|----------------|-----|---|
|                | —   | (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.                             |
| 42 CFR 435.230 | - — | (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.                            |
|                | —   | (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.                         |
|                | —   | (7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230. |
|                | —   | (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.     |
|                | —   | (9) Individuals in additional classifications approved by the Secretary as follows:   |

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TN No. 91-21

Supersedes

TN No. 89-2

Approval Date 10/13/92

Effective Date 10/01/91

HCFA ID: 7983E

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

ATTACHMENT 2.2-A  
Page 16a  
OMB NO.: 0938-

State: HAWAII

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Agency*	Citation(s)	Groups Covered
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**B. Optional Groups Other Than the Medically Needy**  
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

- Yes.

- No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

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TN No. 91-21  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

Approval Date 10/13/92

Effective Date 10/01/91

HCFA ID: 7983E

State: HAWAII

Agency\* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.121  
and 435.230  
1902(a)(10)(A)  
(ii)(XI) of the  
ACT

11. Section 1902(f) States and SSI criteria States  
without agreements under section 1616 or 1634  
of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in each classification and available on a Statewide basis.
- d. Paid to one or more of the classifications of individuals listed below:
  - \_\_\_ (1) All aged individuals.
  - \_\_\_ (2) All blind individuals.
  - \_\_\_ (3) All disabled individuals.

TN No. 91-21  
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State: HAWAII

ATTACHMENT 2.2-A  
Page 18  
OMB NO.: 0938-

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

- |          |     |   |
|----------|-----|---|
| <u>X</u> | (4) | Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.                           |
| <u>X</u> | (5) | Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.                          |
| <u>X</u> | (6) | Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.                       |
| —        | (7) | Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230. |
| —        | (8) | Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.   |
| —        | (9) | Individuals in additional classifications approved by the Secretary as follows:   |

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AUGUST 1991

ATTACHMENT 2.2-A  
Page 18a  
OMB NO.: 0938-

State: HAWAII

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

Yes

No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

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TN No. 91-21

Supersedes

TN No. \_\_\_\_\_

Approval Date 10/13/92

Effective Date 10/01/91

HCFA ID: 7983E

State: HAWAII

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Agency*	Citation(s)	Groups Covered
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**B. Optional Groups Other Than the Medically Needy**  
(Continued)

42 CFR 435.231   
1902(a)(10)  
(A)(ii)(V)  
of the Act

12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.

The State covers all individuals as described above.

The State covers only the following group or groups of individuals:

1902(a)(10)(A)  
(ii) and 1905(a)  
of the Act

- Aged
- Blind
- Disabled
- Individuals under the age of--
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women

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TN No. 91-21  
Supersedes  
TN No. 89-3

Approval Date 10/13/92

Effective Date 10/01/91

HCFA ID: 7983E

State: HAWAII

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Agency\*      Citation(s)      Groups Covered

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**B. Optional Groups Other Than the Medically Needy**  
(Continued)

- |   |           |  |
|---|-----------|--|
| 1902(e)(3)<br>of the Act                                | <u>17</u> | 13.    Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act. <u>Supplement 3 to ATTACHMENT 2.2-A</u> describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.   |
| 1902(a)(10)<br>(A)(11)(IX)<br>and 1902(1)<br>of the Act | <u>18</u> | 14.    The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in <u>Supplement to ATTACHMENT 2.6-A</u> for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in <u>Supplement 2 to ATTACHMENT 2.6-A</u> :<br><br>a.    Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and<br><br>b.    Infants under one year of age. |

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TN No. 91-21      Approval Date 10/13/92      Effective Date 10/01/91  
Supersedes      TN No. 90-11      HCFA ID: 7983E

State: HAWAII

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Agency\*      Citation(s)                                      Groups Covered

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B. Optional Groups Other Than the Medically Needy  
(Continued)

1902(a)      LX/  
(11)(X)  
and 1902(m)  
(1) and (3)  
of the Act ;

16. Individuals--

- a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.
- b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and
- c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.

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TN No. 91-21

Supersedes

TN No. 88-38

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HCFA ID: 7983E



State/Territory:

HAWAII

Citation

Groups Covered

B. Optional Coverage Other Than the Medically Needy  
(Continued)

1906 of the  
Act

18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of \_\_\_\_\_ months.

1902(a)(10)(F)  
and 1902(u)(1)  
of the Act

19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.

TN No. 01-006

Supersedes

TN No. \_\_\_\_\_

Approval Date: OCT 18 2001 Effective Date: \_\_\_\_\_

JUL 11 2001

State: HAWAII

\_\_\_\_\_ The following reasonable classifications of children described above who are under age \_\_\_\_\_ (18, 19) with family income at or below the percent of the Federal poverty level specified for the classification:

(ADD NARRATIVE DESCRIPTION(S) OF THE REASONABLE CLASSIFICATION(S) AND THE PERCENT OF THE FEDERAL POVERTY LEVEL USED TO ESTABLISH ELIGIBILITY FOR EACH CLASSIFICATION.)

1902(e)(12) of the Act

\_\_\_\_\_ 21. A child under age \_\_\_\_\_ (not to exceed age 19) who has been determined eligible is deemed to be eligible for a total of \_\_\_\_\_ months (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above.

1920A  
1902A of the Act

\_\_\_\_\_ 22. Children under age 19 who are determined by a "qualified entity" (as defined in §1902(b)(3)(A)) based on preliminary information, to meet the highest applicable income criteria specified in this plan.

The presumptive period begins on the day that the determination is made. If an application for Medicaid is filed on the child's behalf by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the day that the State agency makes a determination of eligibility based on that application. If an application is not filed on the child's behalf by the last day of the month following the month the determination of presumptive eligibility was made, the presumptive period ends on that last day.

TN No. 01-006

Supersedes

TN No. 00-004

Approval Date: OCT 18 2001 Effective Date: JUL 1 2001

State: HAWAII

Citation(s)	Groups Covered
1902(a)(10)(A) and 1920 of the Act	<p>B. <u>Optional Coverage Other Than the Medically Needy (Continued)</u></p> <p><u>X</u> 23. Women who:</p> <p>a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;</p> <p>b. are not otherwise covered under creditable coverage, as defined in section 2701 (c) of the Public Health Service Act;</p> <p>c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and</p> <p>d. have not attained age 65.</p>
1920B of the Act	<p>24. Women who are determined by a "qualified entity" (as defined in 1920B (b) based on preliminary information, to be a woman described in 1902 (aa) of the Act related to certain breast and cervical cancer patients.</p>

The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.

State: HAWAII

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Agency*	Citation(s)	Groups Covered
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**C. Optional Coverage of the Medically Needy**

42 CFR 435.301 This plan includes the medically needy.

No.

Yes. This plan covers:

1902(e) of the Act

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60 day falls.

1902(a)(10)(C)(i)(I) of the Act

3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.

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TN No. 91-21

Supersedes

TN No. \_\_\_\_\_

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HCFA ID: 7983E

State: HAWAII

Agency\* Citation(s) Groups Covered

C. Optional Coverage of Medically Needy (Continued)

1902(e)(4) of  
the Act

4. Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains eligible and the child is a member of the woman's household.

42 CFR 435.308

5.  a. Financially eligible individuals who are not described in section C.3. above and who are under the age of--  
\_\_\_ 21  
\_\_\_ 20  
\_\_\_ 19  
\_\_\_ 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training

b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

- (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:
- (a) In foster homes (and are under the age of 21).
  - (b) In private institutions (and are under the age of 21).

TN No. 91-21  
Supersedes  
TN No. \_\_\_\_\_

Approval Date 10/13/92

Effective Date 10/01/91

HCFA ID: 7983E

State: HAWAII

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Agency\*      Citation(s)                      Groups Covered

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C. Optional Coverage of Medically Needy (Continued)

- X (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of 21).
- X (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of 21).
- X (3) Individuals in NFs (who are under the age of 19). NF services are provided under this plan.
- X (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of 19).
- X (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of 19). Inpatient psychiatric services for individuals under age 21 are provided under this plan.
- X (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

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TN No. 91-21  
Supersedes  
TN No. 90-1

Approval Date 10/13/92

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HCFA ID: 7983E

State: Hawaii

Agency *	Citation(s)	Group Covered
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C. Optional Coverage of Medically Needy  
(continued)

- |                               |                                     |   |
|-------------------------------|-------------------------------------|---|
| 42 C.F.R. 435.310             | <input type="checkbox"/>            | 6. Caretaker relatives  |
| 42 C.F.R. 435.320 and 435.330 | <input checked="" type="checkbox"/> | 7. Aged individuals   |
| 42 C.F.R. 435.322 and 435.330 | <input checked="" type="checkbox"/> | 8. Blind individuals  |
| 42 C.F.R. 435.324 and 435.330 | <input checked="" type="checkbox"/> | 9. Disabled individuals   |
| 42 C.F.R. 435.326             | <input type="checkbox"/>            | 10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 C.F.R. 212 and the same rules apply to medically needy individuals.   |
| 42 C.F.R. 435.326             |                                     | 11. Blind and disabled individuals who:<br>a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;<br>b. Were eligible as medically needy in December 1973 as blind or disabled; and<br>c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria. |

TN No.	<u>13-004b</u>	Approval Date:	<u>09/30/2013</u>	Effective Date:	<u>01/01/2014</u>
Supersedes					
TN No.	<u>91-21</u>				

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE  
PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency	Citation(s)	Groups Covered
1935(a) and 1902(a)(66) 42 CFR 423.774 and 423.904		<p>The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act.</p> <ol style="list-style-type: none"><li>1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act;</li><li>2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined;</li><li>3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.</li></ol>

TN No. 05-005

Supersedes

TN No. \_\_\_\_\_

Approval Date:

SEP 02 2005

Effective Date:

07/01/05



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

REASONABLE CLASSIFICATION OF INDIVIDUALS UNDER THE AGE OF 21, 20, 19 AND 18

Other classification of financially eligible children: (continue)

- e. 2101(f)-Like Children: Children under age 19 years who were enrolled in Medicaid on December 31, 2013 and would otherwise become ineligible for Medicaid at their first determination using Modified Adjusted Gross Income (MAGI) based methodologies solely due to the loss of income disregards will remain Medicaid eligible until their next redetermination using MAGI methodologies. (42 C.F.R. 435.222)

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TN No.	<u>13-011</u>	Approval Date:	<u>03/13/2014</u>	Effective Date:	<u>12/31/2013</u>
Supersedes					
TN No.	<u>NEW</u>				

Revision: HCFA-PH-87-4 (BERC)  
MARCH 1987

SUPPLEMENT 2 TO ATTACHMENT 2.2-A  
Page 1  
OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

~~XXXXXXXX~~ State: HAWAII

A. DEFINITION OF BLINDNESS IN TERMS OF OPHTHALMIC MEASUREMENT

~~Individual is medically certified to have a central visual---  
acuity of 20/200, or less, in the better eye with correcting  
lenses or have a field subtends an angular distance no--  
greater than twenty degrees (tunnel vision)---~~

Not applicable.

\*Agency that determines eligibility for coverage.

TN No. 87-11  
Supersedes  
TN No. 1/a

Approval Date NOV 17 1987

Effective Date 7/1/87

HCFA ID: 2002P/0021P

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

SUPPLEMENT 3 TO ATTACHMENT 2.2-A  
Page 1  
OMB NO.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

Method for Determining Cost Effectiveness of Caring for  
Certain Disabled Children At Home

Not Applicable

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TN No. 91-21  
Supersedes \_\_\_\_\_ Approval Date 10/13/92 Effective Date 10/01/91  
TN No. \_\_\_\_\_ HCFA ID: 7983E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
<b>A. <u>General Conditions of Eligibility</u></b>	
Each individual covered under the plan:	
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	2. Meets the applicable non-financial eligibility conditions.
	a. For the categorically needy:
	(i) Except as specified under items A.2.a.(i) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
1902(l) of the Act	(iii) For financially eligible pregnant women, infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(i)(IX) of the Act, meets the non-financial criteria of section 1902(l) of the Act.
1902(m) of the Act	(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(i)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: Hawaii

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation	Condition or Requirement
1905 (p) of the Act	<ul style="list-style-type: none"><li>b. For the medically needy, meets the non-financial eligibility condition of 42 CFR Part 435.</li><li>c. For financially eligible qualified Medicare beneficiaries covered under section 1902 (a) (10) (E) (i) of the Act, meets the non-financial criteria of section 1905 (p) of the Act.</li></ul>
1905 (s) of the Act	<ul style="list-style-type: none"><li>d. For financially eligible qualified disabled and working individuals covered under section 1902 (a) (10) (E) (ii) of the Act, meets the non-financial criteria of section 1905(s).</li></ul>
42 CFR 435.406	<p>3. Is residing in the United States and --</p> <ul style="list-style-type: none"><li>a. Is a citizen or national of the United States;</li><li>b. Is a qualified alien (QA) as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) as amended, and the QA's eligibility is required by section 402 (b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended;</li><li>c. Is a qualified alien subject to the 5-year bar as described in section 403 of PRWORA, so that eligibility is limited to treatment of an emergency medical condition defined in section 401 of PRWORA;</li></ul>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: Hawaii

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation	Condition or Requirement
	d. Is a non-qualified alien, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;
	e. Is a qualified alien (QA) whose eligibility is authorized under section 402 (b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended. <u>X</u> State covers all authorized QAs. _____ State does not cover authorized QAs.
	f. State elects CHIPRA option to provide full Medicaid coverage to otherwise eligible aliens lawfully residing in the United States; such aliens consist of qualified aliens subject to the 5-year bar, aliens described in 8 CFR 103.12 (a)(4), and legal non-immigrants whose admission to the U.S. is not conditioned on having a permanent residence in a foreign country (such non-immigrants include citizens of the Compact of Free Association States who are considered permanent non-immigrant but does not include visitors for business or pleasure or student): <u>X</u> Elected for pregnant women. <u>X</u> Elected for children under age 19
42 CFR 435.406 1902 (b) of the Act	4. Is a resident of the State, regardless whether or not the individual maintains the residence permanently or maintains it at a fixed address. <input type="checkbox"/> State has interstate residency agreement with the following States: <input type="checkbox"/> State has open agreement(s). <input type="checkbox"/> Not applicable; no residency requirement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 C.F.R. 435.1008	5. a. Is not an inmate of a public institution. Public institution do not include medical institutions, nursing facilities and intermediate care facilities for the mentally retarded, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 C.F.R. 435.1008 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. <input checked="" type="checkbox"/> Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
42 C.F.R. 433.145 and 435.604 1912 of the Act	6. Is required, as a condition of eligibility, to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment to medical support and payment for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court or administrative order.) <input checked="" type="checkbox"/> Assignment of rights is automatic because of State law.
42 C.F.R. 435.910	7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number). Exception, aliens seeking medical assistance for the treatment of an emergency medical condition under Section 1903(v)(2) of the Social Security Act (Section 1137(f)).

TN No. 13-004b

Supersedes

Approval Date:

09/30/2013

Effective Date:

01/01/2014

TN No.

91-21

State: HAWAII

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Citation	Condition or Requirement
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Citation:

1906 of the Act

10. Conflict of Interest Provisions

Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

U.S. Supreme  
Court case *New York State Department of Social Services v. Dublino*, 413 U. S. 405 (1973)

- X 11. Is required to apply for coverage under Medicare Parts A, B, and/or D if it is likely that the individual would meet the eligibility criteria for any or all of those programs. The state agrees to pay any applicable premiums and cost-sharing (except those applicable under Part D) for individuals required to apply for Medicare. Application for Medicare is a condition of eligibility unless the state does not pay the Medicare premiums, deductibles or co-insurance (except those applicable under Part D) for persons covered by the Medicaid eligibility group under which the individual is applying.

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TN No. 05-008

Supersedes

TN No. \_\_\_\_\_

Approval Date: NOV 18 2005

Effective Date: \_\_\_\_\_

01/01/06



State: HAWAII

Citation	Condition or Requirement
<b>B. Posteligibility Treatment of Institutionalized Individuals' Incomes</b>	
1. The following items are not considered in the posteligibility process:	
1902(o) of the Act	a. SSI and SSP benefits paid under §1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.
Bondi v Sullivan (SSI)	b. Austrian Reparation Payments (pension (reparation) payments made under §500 - 506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.
1902(r)(1) of the Act	c. German Reparations Payments (reparation payments made by the Federal Republic of Germany).
105/206 of P. L. 100-383	d. Japanese and Aleutian Restitution Payments.
1. (a) of P.L. 103-286	e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).
10405 of P.L. 101-239	f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.)
6(h)(2) of P.L. 101-426	g. Radiation Exposure Compensation.
12005 of P. L. 103-66	h. VA pensions limited to \$90 per month under 38 U.S.C. 5503.

TN No. 98-003

Supersedes

Approval Date 12/11/98

Effective Date 12/1/98

TN No. 91-21

State: HAWAII

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Citation	Condition or Requirement
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1924 of the Act  
435.725  
435.733  
435.832

2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care:

Personal Needs Allowance (PNA) of not less than \$50 for Individuals and \$100 for Couples for all Institutionalized Persons.

- a. Aged, blind, disabled:

Individuals \$ 50.00  
Couples \$ 100.00

For the following persons with greater need:

Supplement 12a to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

- b. AFDC related:

Children \$ 50.00  
Adults \$ 50.00

For the following persons with greater need:

Supplement 12a to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

- c. Individual under age 21 covered in the plan as specified in Item B. 7. of Attachment 2.2 -A.  
\$ N/A

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TN No. 07-006  
Supersedes  
TN No. 98-003

Approval Date: DEC 12 2007 Effective Date: 07/01/07

State: HAWAII

Citation

Condition or Requirement

For the following persons with greater need:

1. <sup>12a</sup> Supplement ~~ix~~ to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

1924 of the Act

3. In addition to the amounts under item 2., the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse:

a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1924(d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.

\_\_\_\_\_ The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level.

\_\_\_\_\_ The poverty level component is calculated using a percentage greater than the applicable percentage, equal to \_\_\_\_\_%, of the official poverty level (still subject to maximum maintenance needs standard).

X The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C).

Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.

TN No. 98-003

Supersedes \_\_\_\_\_

Approval Date 12/1/98

Effective Date 10/1/98

TN No. \_\_\_\_\_

Revision: HCFA-PM-97-2  
December 1997

ATTACHMENT 2.6-A  
Page 4c  
OMB No.:0938-0673

State: HAWAII

Citation	Condition or Requirement
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In determining any excess shelter allowance, utility expenses are calculated using:

\_\_\_\_\_ the standard utility allowance under §5(e) of the Food Stamp Act of 1977; or

\_\_\_\_\_ the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.

b. The monthly income allowance for other dependent family members living with the community spouse is:

X one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924 (d)(3)(B)) exceeds the dependent family member's monthly income.

\_\_\_\_\_ a greater amount calculated as follows:

The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924 (d)(1):

c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party:

(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)

TN No. 98-003  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

Approval Date 12/11/98

Effective Date 12/11/98

State: HAWAII

Citation \_\_\_\_\_ Condition or Requirement \_\_\_\_\_

435.725  
435.733  
435.832

4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple:
- a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:
    - o AFDC level; or
    - o Medically needy level:

(Check one)

- AFDC levels in Supplement 1
- Medically needy level in Supplement 1
- Other: \$ \_\_\_\_\_

- b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party:

(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to ATTACHMENT 2.6-A.)

435.725  
435.733  
435.832

5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple:

A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:

No.

Yes (the applicable amount is shown on page 5a.)

TN No. 98-003

Supersedes  
TN No. 91-21

Approval Date 12/11/98

Effective Date 10/1/98

Revision: HCFA-PM-97-2  
December 1997

ATTACHMENT 2.6-A  
Page 5a  
OMB No.:0938-0673

State: HAWAII

Citation	Condition or Requirement
_____	Amount for maintenance of home is: \$ _____
_____	Amount for maintenance of home is the actual maintenance costs not to exceed \$ _____
_____	Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individuals' home and the community spouse's home are different.
_____	Amount for maintenance of home is not deductible when countable income is determined under §1924 (d)(1) of the Act.

TN No. 98-003  
Supersedes 94-002  
TN No. \_\_\_\_\_

Approval Date 12/1/98

Effective Date 10/1/98

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Citation

Condition or Requirement

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"Dependency" means the status of a child, parent, or sibling who resides with the community spouse, and who may be claimed as a legal tax dependent of either spouse under the Internal Revenue Code.

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TN No. 89-10  
Supercedes  
TN No. \_\_\_\_\_

Approval Date 09/13/90

Effective Date 10/01/89

State: Hawaii

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
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42 C.F.R. 435.601, 435.631,  
435.831

C. Financial Eligibility

For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below.

For individuals who are not AFDC or SSI recipients a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section apply.

Supplement 1 to Attachment 2.6-A specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the Federal income poverty level - pregnant women and infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act and aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act - and for mandatory groups of qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act.

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TN No.	<u>13-010</u>	Approval Date:	<u>02/12/2014</u>	Effective Date:	<u>10/01/2013</u>
Supersedes					
TN No.	<u>92-15</u>				



State: Hawaii

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	<input checked="" type="checkbox"/> <u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.
	<input checked="" type="checkbox"/> <u>Supplement 7 to ATTACHMENT 2.6-A</u> specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.
	<input checked="" type="checkbox"/> <u>Supplement 4 to ATTACHMENT 2.6-A</u> specifies the methods for determining income eligibility used by states that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
	<input checked="" type="checkbox"/> <u>Supplement 5 to ATTACHMENT 2.6-A</u> specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
	<input checked="" type="checkbox"/> <u>Supplement 8a to ATTACHMENT 2.6-A</u> specifies the methods for determining income eligibility used by States are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
	<input checked="" type="checkbox"/> <u>Supplement 8b to ATTACHMENT 2.6-A</u> specifies the methods for determining resource eligibility used by States are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
	<input type="checkbox"/> <u>Supplement 14 to ATTACHMENT 2.6-A</u> specifies income levels used by States for determining resource eligibility of Tuberculosis-infected individuals whose eligibility is determined under §1902(z)(1) of the Act.

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TN No. 13-010  
Supersedes 92-15 Approval Date: 02/12/2014 Effective Date: 10/01/2013

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(r)(2) of the Act	1. <u>Methods of Determining Income</u> <u>A. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).</u>  (1) In determining countable income for AFDC-related individuals, the following methods are used:  <input checked="" type="checkbox"/> (a) The methods under the State's approved AFDC plan only; or  <input type="checkbox"/> (b) The methods under the State's approved AFDC plan and/or any liberal methods described in Supplement 8a to ATTACHMENT 2.6  (2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.  (3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, with regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends on any remaining days in the month in which 60th day falls.

1902(e)(6)  
the Act

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.721 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act	b. <u>Aged individuals.</u> In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used:

- The methods of the SSI program only.
- The methods of the SSI program and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

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Citation	Condition or Requirement
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- For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
- For institutional couples, the methods specified under section 1611(e)(5) of the Act.
- For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.
- For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--
  - SSI methods.
  - SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.
  - Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

State: HAWAII

Citation	Condition or Requirement
42 CFR 435.721 and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	c. <u>Blind individuals.</u> In determining countable income for blind individuals, the following methods are used:
	<input checked="" type="checkbox"/> The methods of the SSI program. <u>enlyx</u>
	<input type="checkbox"/> SSI methods and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>
	<input checked="" type="checkbox"/> For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A,</u> and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>
	<input type="checkbox"/> For institutional couples, the methods specified under section 1611(e)(3) of the Act.
	<input type="checkbox"/> For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A.</u>
	<input checked="" type="checkbox"/> For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--
	<input checked="" type="checkbox"/> SSI methods. <u>enlyx</u>
	<input type="checkbox"/> SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>
	<input checked="" type="checkbox"/> Methods more restrictive and/ or more liberal than SSI. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>

TN No. 91-21

Supersedes

TN No. \_\_\_\_\_

Approval Date 10/13/92

Effective Date 10/01/91

HCFA ID: 7985E

State: HAWAII

Citation	Condition or Requirement
42 CFR 435.721, and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
	d. <u>Disabled individuals.</u> In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used:
	<ul style="list-style-type: none"><li><input checked="" type="checkbox"/> The methods of the SSI program</li><li><input type="checkbox"/> SSI methods and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></li><li><input type="checkbox"/> For institutional couples: the methods specified under section 1611(e)(5) of the Act.</li><li><input type="checkbox"/> For optional State supplement recipients under \$435.230: income methods more liberal than SSI, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A.</u></li><li><input checked="" type="checkbox"/> For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A;</u> and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></li></ul>

TN No. 91-21  
Supersedes  
TN No. \_\_\_\_\_

Approval Date 10/13/92

Effective Date 10/01/91

HCFA ID: 7985E

State: HAWAII

Citation	Condition or Requirement
<u>X</u>	For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--
<u>X</u>	SSI methods. <del>and/or</del>
<u>---</u>	SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .
<u>X</u>	Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are specified in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

TN No. 91-21  
Supersedes  
TN No. \_\_\_\_\_

Approval Date 10/13/92

Effective Date 10/01/91

HCFA ID: 79838

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(e)(6) of the Act	(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act	(3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.  f. <u>Qualified Medicare beneficiaries.</u> In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(B)(i) of the Act, the following methods are used:  <input checked="" type="checkbox"/> <u>X</u> The methods of the SSI program only.  <input type="checkbox"/> SSI methods and/or any more liberal method than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>  <input type="checkbox"/> For institutional couples, the methods specified under section 1611(e)(5) of the Act.



State: HAWAII

Citation

Condition or Requirement

If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.

1905(s) of the Act

g. (1) Qualified disabled and working individuals.

In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.

1905(p) of the Act

(2) Specified low-income Medicare beneficiaries.

In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.

No. 93-03

Supersedes

TN No. 92-15

Approval Date 5/3/93

Effective Date 1/1/93

TN

State: HAWAII

Citation	Condition or Requirement
1902(k) of the Act	<p data-bbox="651 390 1130 422"><b>2. Medicaid Qualifying Trusts</b></p> <p data-bbox="699 443 1602 800">In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.</p> <p data-bbox="704 827 1588 961"><input checked="" type="checkbox"/> The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. <u>Supplement 10 of ATTACHMENT 2.6-A</u> specifies what constitutes an undue hardship.</p>
1902(a)(10) of the Act	<p data-bbox="659 989 1503 1041"><b>3. Medically needy income levels (MNILs) are based on family size.</b></p> <p data-bbox="708 1068 1602 1180"><u>Supplement 1 to ATTACHMENT 2.6-A</u> specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, <u>Supplement 1</u> so indicates.</p>

TN No. 91-21  
Supersedes  
TN No. 88-18

Approval Date 10/13/92

Effective Date 10/01/91

HCFA ID: 7985E

State: HAWAII

Citation	Condition or Requirement
42 CFR 435.732, 435.831	<p>4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only</p> <p>a. <u>Medically Needy</u></p> <p>(1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of <del>either</del> <u>one or</u> <u>_____</u> month(s) (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services.</p> <p>(2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:</p> <p>(a) Health insurance premiums, deductibles and coinsurance charges.</p> <p>(b) Expenses for necessary medical and remedial care not included in the plan.</p> <p>(c) Expenses for necessary medical and remedial care included in the plan.</p> <p>_____ Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.</p>

1902(a)(17) of the Act

Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

TN No. 91-21  
Supersedes  
TN No. 88-18

Approval Date 10/13/92

Effective Date 10/01/91

HCFA ID: 7985E

State/Territory State of Hawaii

Citation	Condition or Requirement
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Medically Needy (continued)

1902(a) (17)  
435.831(g) (2)  
436.831(g) (2)

States are permitted to exclude from incurred medical expenses those bills for services furnished more than three months before a Medicaid Application.

Yes, the State elects to exclude such expenses.

No, the State does not elect to exclude such expenses.

\* As a 209(b) state, Hawaii is required to allow for incurred medical expenses regardless of when the expenses were incurred.

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

ATTACHMENT 2.6-A  
Page 15  
OMB No.: 0938-

State: HAWAII

Citation	Condition or Requirement
42 CFR 435.732	<b>b. Categorically Needy - Section 1902 (f) States</b>
1902(a)(17) of the Act, P.L. 100-203	The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income:  (1) Any SSI benefit received.  (2) Any State supplement received that is within the scope of an agreement described in section 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act.  (3) Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section.  (4) Other deductions from income described in this plan at <u>Attachment 2.6-A, Supplement 4</u> .  (5) Incurred expenses for necessary medical and remedial services recognized under State law.  Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

TN No. 91-21  
Supersedes  
TN No. 88-18

Approval Date 10/13/92

Effective Date 10/01/91

HCFA ID: 7905E

State: HAWAII

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Citation	Condition or Requirement
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5. Methods for Determining Resources

1902(a)(10)(A),  
1902(a)(10)(C),  
1902(m)(1)(B)  
and (C), and  
1902(r) of the Act

b. Aged individuals. For aged individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources:

- The methods of the SSI. ~~program~~
- SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.
- Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

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TN No. 91-21  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

Approval Date 10/13/92

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HCFA ID: 7985E

State: HAWAII

Citation	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902(r) of the Act	<p data-bbox="805 394 1602 510">In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.</p> <p data-bbox="704 537 1417 617">c. <u>Blind individuals.</u> For blind individuals the agency uses the following methods for treatment of resources:</p> <ul style="list-style-type: none"><li data-bbox="756 646 1352 674"><input checked="" type="checkbox"/> The methods of the SSI program.</li><li data-bbox="756 701 1450 781">— SSI methods and/or any more liberal methods described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u></li><li data-bbox="756 808 1580 968"><input checked="" type="checkbox"/> Methods that are more restrictive and/or more liberal than those of the SSI program. <u>Supplement 5 to ATTACHMENT 2.6-A</u> describe the more restrictive methods and <u>Supplement 8b to ATTACHMENT 2.6-A</u> specify the more liberal methods.</li></ul> <p data-bbox="756 997 1602 1134">In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>

TN No. 91-21  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

Approval Date 10/13/92

Effective Date 10/01/91

HCFA ID: 7985E

State: HAWAII

Citation	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act	<p>d. <u>Disabled individuals, including individuals covered under section 1902(a)(10)(A)(i)(X) of the Act.</u> The agency uses the following methods for the treatment of resources:</p> <ul style="list-style-type: none"><li><input checked="" type="checkbox"/> The methods of the SSI program.</li><li><input type="checkbox"/> SSI methods and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></li><li><input checked="" type="checkbox"/> Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those under the SSI program. More restrictive methods are described in <u>Supplement 5 to ATTACHMENT 2.6-A</u> and more liberal methods are specified in <u>Supplement 8b to ATTACHMENT 2.6-A.</u></li></ul> <p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>
1902(l)(3) and 1902(r)(2) of the Act	<p>e. <u>Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(i)(IX)(A) of the Act.</u></p> <p>The agency uses the following methods in the treatment of resources.</p> <ul style="list-style-type: none"><li><input type="checkbox"/> The methods of the SSI program only.</li><li><input type="checkbox"/> The methods of the SSI program and/or any more liberal methods described in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u></li></ul>

TN No. 91-21  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

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HCFA ID: 7965E



State: HAWAII

Citation	Condition or Requirement
1905(p)(1) (C) and (D) and 1902(r)(2) of the Act	5. h. <u>Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act--</u>  The agency used the following methods for treatment of resources:  ___ The methods of the SSI program only.  <u>X</u> The methods of the SSI program and/or more liberal methods as described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u>
1905(a) of the Act	1. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.  6. Resource Standard - Categorically Needy  a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:  <u>X</u> Same as SSI resource standards.  ___ More restrictive.  The resource standards for other individuals are the same as those in the related cash assistance program.  b. Non-1902(f) States (except as specified under items 6.c. and d. below)  The resource standards are the same as those in the related cash assistance program.  <u>Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.</u>

TN No. 91-21  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

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Effective Date 10/01/91

HCFA ID: 7985E

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

ATTACHMENT 2.6-A  
Page 21a  
OMB No.: 0938-

State: HAWAII

Citation	Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	e. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(i)(X) of the Act, the resource standard is:  <input checked="" type="checkbox"/> Same as SSI resource standards.  <input type="checkbox"/> Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy).  <u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the resource levels for these individuals.

TN No. 91-21  
Supersedes  
TN No. \_\_\_\_\_

Approval Date 10/13/92

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HCFA ID: 7985E

State: Hawaii

Citation	Condition or Requirement
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1902(a)(10)(C)(I)  
of the Act

7. Resource Standard –Medically Needy
- a. Resource standards are based on family size.
  - b. A single standard is employed in determining resource eligibility for all groups.
  - c. In 1902(f) States, the resource standards is more restrictive than in 7.b. above for --
    - \_\_\_\_\_ Aged
    - \_\_\_\_\_ Blind
    - \_\_\_\_\_ Disabled

Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2,so indicates.

1902(a)(10)(E),  
1905(p)(1)(C),  
1905(p)(2)(B) and  
1860D-14(a)(3)(D)  
of the Act

8. Resource Standard – Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals

For qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(I) of the Act, Specified Low-Income Medicare Beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individuals covered under 1902(a)(10)(E)(iv) of the Act, the resource standard is three times the SSI resource limit, adjusted annually since 1996 by the increase in the consumer price index.

TN No. 10-001  
Supersedes  
TN No. 91-21

Approval Date: MAY 28 2010

Effective Date: 01/01/10

State: Hawaii

1902(a)(10)(E)(ii) and  
1905(a) of the Act

9. Resource Standard - Qualified Disabled and Working  
Individuals

For qualified disabled and working individuals covered under  
section 1902(a)(10)(E)(ii) of the Act, the resource standard  
for an individual or a couple (in the case of an individual with  
a spouse) is two times the SSI resource limit.

TN No. 10-001  
Supersedes  
TN No. 91-21

Approval Date: MAY 28 2010

Effective Date: 01/01/10

State: HAWAII

Citation

Condition or Requirement

10. Excess Resources

- a. Categorically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals

Any excess resources make the individual ineligible.

- b. Categorically Needy Only

This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources.

- c. Medically Needy

Any excess resources make the individual ineligible.

TN No. 91-21  
Supersedes  
TN No. \_\_\_\_\_

Approval Date 10/13/92

Effective Date 10/01/91

HCFA ID: 7985E

State: HAWAII

Citation	Condition or Requirement
42 CFR 435.914	<p>11. Effective Date of Eligibility</p> <p>a. Groups Other Than Qualified Medicare Beneficiaries</p> <p>(1) For the prospective period.</p> <p>Coverage is available for the full month if the following individuals are eligible at any time during the month.</p> <p><input checked="" type="checkbox"/> Aged, blind, disabled. <input checked="" type="checkbox"/> AFDC-related.</p> <p>Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.</p> <p><input type="checkbox"/> Aged, blind, disabled. <input type="checkbox"/> AFDC-related.</p> <p>(2) For the retroactive period.</p> <p>Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:</p> <p><input type="checkbox"/> Aged, blind, disabled. <input type="checkbox"/> AFDC-related.</p> <p>Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied..</p> <p><input checked="" type="checkbox"/> Aged, blind, disabled. <input checked="" type="checkbox"/> AFDC-related.</p>

TN No. 91-21  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

Approval Date 10/13/92

Effective Date 10/01/91

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1920(b)(1) of the Act	<p>(3) For a presumptive eligibility period for pregnant women only.</p> <p>Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in ATTACHMENT 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.</p>
1902(e)(8) and 1905(a) of the Act	<p><u>X</u> b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for--</p> <p><u>X</u> 12 months</p> <p>___ 6 months</p> <p>___ months (no less than 6 months and no more than 12 months)</p>

Citation

Condition or Requirement

1902(a)(10)  
and 1902(f) of  
the Act

12. Pre-OBRA 93 Transfer of Resources -  
Categorically and Medically Needy, Qualified Medicare  
Beneficiaries, and Qualified Disabled and Working  
Individuals

The agency complies with the provisions of section 1917  
of the Act with respect to the transfer of resources.

Disposal of resources at less than fair market value  
affects eligibility for certain services as detailed  
in Supplement 9 to Attachment 2.6-A.

1917(c)

13. Transfer of Assets - All eligibility groups

The agency complies with the provisions of section  
1917(c) of the Act, as enacted by OBRA 93, with regard  
to the transfer of assets.

Disposal of assets at less than fair market value  
affects eligibility for certain services as detailed  
in Supplement 9(a) to ATTACHMENT 2.6-A, except in  
instances where the agency determines that the transfer  
rules would work an undue hardship.

1917(d)

14. Treatment of Trusts - All eligibility groups

The agency complies with the provisions of section  
1917(d) of the Act, as amended by OBRA 93, with regard  
to trusts.

— The agency uses more restrictive methodologies  
under section 1902(f) of the Act, and applies  
those methodologies in dealing with trusts;

— The agency meets the requirements in section  
1917(d)(4)(B) of the Act for use of Miller  
trusts. A

The agency does not count the funds in a trust in any  
instance where the agency determines that the transfer  
would work an undue hardship, as described in  
Supplement 10 to ATTACHMENT 2.6-A.



Revision: HCFA-PM-97-3  
December 1997

ATTACHMENT 2.6-A  
Page 26a  
OMB No.:0938-0673

State: HAWAII

Citation \_\_\_\_\_ Condition or Requirement \_\_\_\_\_

1924 of the Act

13. The agency complies with the provisions of §1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community.

When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is:

- the maximum standard permitted by law,  
 the minimum standard permitted by law, or  
 a standard that is an amount between the minimum and the maximum.

TN No. 98-003

Supersedes \_\_\_\_\_

TN No. \_\_\_\_\_

Approval Date 12/1/95

Effective Date 10/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: HAWAII

INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m)(3) of the Act are as follows:

Based on 100 percent of the official Federal income poverty line.

<u>Family Size</u>	<u>Income Level</u>
<u>1</u>	\$ <u>*</u>
<u>2</u>	\$ <u>*</u>
<u>3</u>	\$ <u>*</u>
<u>4</u>	\$ <u>*</u>
<u>5</u>	\$ <u>*</u>

If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

\*Amount equal to 100% of the federal poverty level for a family of applicable size and updated annually as published in the Federal Register.

TN No. 92-15  
Supersedes  
TN No. 91-21

Approval Date 10/29/92

Effective Date 7/1/92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of section 1905(p)(2)(A) of the Act are as follows:

1. NON-SECTION 1902(f) STATES

a. Based on the following percent of the official Federal income poverty level:

- Eff. Jan. 1, 1989:  85 percent  \_\_\_\_\_ percent (no more than 100)
- Eff. Jan. 1, 1990:  90 percent  \_\_\_\_\_ percent (no more than 100)
- Eff. Jan. 1, 1991: 100 percent
- Eff. Jan. 1, 1992: 100 percent

b. Levels:

Family Size

1  
2

Income Levels

\$ \* \_\_\_\_\_  
\$ \* \_\_\_\_\_

\*Amount equal to 100% of the federal poverty level for a family of applicable size, as revised annually in the Federal Register.

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TN No. 91-21 Approval Date 10/13/92 Effective Date 10/01/91  
 Supersedes \_\_\_\_\_  
 TN No. \_\_\_\_\_ HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. SECTION 1902(f) STATES WHICH AS OF JANUARY 1, 1987 USED INCOME STANDARDS MORE RESTRICTIVE THAN SSI

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan. 1, 1989:  80 percent  100 percent (no more than 100 percent)  
Eff. Jan. 1, 1990:  85 percent  100 percent (no more than 100 percent)  
Eff. Jan. 1, 1991:  95 percent  100 percent (no more than 100 percent)  
Eff. Jan. 1, 1992: 100 percent

b. Levels:

Family Size

Income Levels

1  
2

\$ \*  
\$ \*

\*Amount equal to federal poverty level for a family of applicable size, as revised annually in the Federal Register

TN No. 91-21

Supersedes

TN No. \_\_\_\_\_

Approval Date 10/13/92

Effective Date 10/01/91

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

Applicable to all groups.

Applicable to all groups except those specified below. Excepted group income levels are also listed on an Attached page 3.

(1) Family Size	(2) Net income level protected for maintenance for <u>one</u> month	(3) Amount by which Column (2) exceeds limits specified in CFR 435.1007 <sup>11</sup>	(4) Net income level for persons living in rural areas for _____ months	(5) Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007 <sup>11</sup>
	<input type="checkbox"/> Urban only			
	<input type="checkbox"/> Urban & rural			
1	\$ 469	\$	\$	\$
2	\$ 632	\$	\$	\$
3	\$ 795	\$	\$	\$
4	\$ 958	\$	\$	\$
For each Additional Person,				
Add:	\$163			

<sup>11</sup> The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

X Applicable to all groups.      Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for <u>one</u> month  <u>    </u> urban only <u>    </u> urban & rural	Amount by which Column (2) exceeds limits specified in CFR 435.1007 <sup>u</sup>	Net income level for persons living in rural areas for <u>    </u> months	Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007 <sup>u</sup>
5	\$ 1,121	\$	\$	\$
6	\$ 1,284	\$	\$	\$
7	\$ 1,447	\$	\$	\$
8	\$ 1,610	\$	\$	\$
9	\$ 1,772	\$	\$	\$
10	\$ 1,935	\$	\$	\$
For each Additional Person, Add:	\$ 163			

<sup>u</sup> The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

TN No. 07-007  
Supersedes  
TN No. 93-007

Approval Date: DEC 12 2007 Effective Date: 07/01/07

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

4. Aged and Disabled Individuals

Same as SSI resource levels for an individual or a couple.

More restrictive than SSI levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	_____
<u>2</u>	_____
<u>3</u>	_____
<u>4</u>	_____
<u>5</u>	_____

Same as medically needy resource levels (applicable only if State has a medically needy program)

TN No. 91-21  
Supersedes \_\_\_\_\_ Approval Date 10/13/92 Effective Date 10/01/91  
TN No. \_\_\_\_\_

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY

Applicable to all groups -

Except those specified below under the provisions of section 1902(f) of the Act.

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>2,000</u>
<u>2</u>	<u>3,000</u>
<u>3</u>	<u>3,250</u>
<u>4</u>	<u>3,500</u>
<u>5</u>	<u>3,750</u>
<u>6</u>	<u>4,000</u>
<u>7</u>	<u>4,250</u>
<u>8</u>	<u>4,500</u>
<u>9</u>	<u>4,750</u>
<u>10</u>	<u>5,000</u>
For each additional person	<u>250</u>

TN No. 91-21 Approval Date 10/13/92 Effective Date 10/01/91  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_ HCFA ID: 7985E



Revision: HCFA-PM-85-3

(BERG)

SUPPLEMENT 3 to ATTACHMENT 2.6-A  
Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL  
OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

The deduction for medical and remedial care expenses that were incurred as the result of the imposition of a transfer of asset penalty period is limited to zero.

TN No. 09-010

Supersedes

TN No. 85-9

Approval Date:

AUG 23 2010

Effective Date:

10/01/09

HCFA ID: 4093E/0002P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM  
THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)

The methodology for treatment of income differs from the SSI program in the following areas where Hawaii is more restrictive.

1. Money received as repayment on loans is not disregarded.
2. Child support payments are counted as unearned income.
3. \$10 exclusion for infrequent or irregular earned income is not allowed.
4. VA aid and attendance payments are not disregarded.

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TN No. 91-21  
Supersedes 88-13 Approval Date 10/13/92 Effective Date 10/01/91  
TN No. 88-13

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

MORE RESTRICTIVE METHODS OF TREATING RESOURCES  
THAN THOSE OF THE SSI PROGRAM - SECTION 1902(f) STATES ONLY

The methodology for treatment of resources differs from the SSI program in the following areas where Hawaii is more restrictive.

1. The value of property other than home property including business property is counted.
2. The equity value of life insurance policies are counted. Equity value of a life insurance policy shall be determined by subtracting any outstanding loans or encumbrances from the cash value of the policy.
3. Income tax refunds are counted as a resource in the month of receipt.

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TN No.	<u>13-004b</u>	Approval Date:	<u>09/30/2013</u>	Effective Date:	<u>01/01/2014</u>
Supersedes					
TN No.	<u>91-21</u>				

Revision: HCFA-PH-91-4 (BPD)  
AUGUST 1991

SUPPLEMENT 3a TO ATTACHMENT 2.6-A  
Page 1  
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS  
WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

Optional coverage categorically needy

- Pregnant women and children - no limit on resources.
- Aged and disabled - not to exceed the maximum amount allowed under the State's medically needy program.

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TN No. 91-21 Approval Date 10/13/92 Effective Date 10/01/91  
Supersedes  
TN No. 88-40 HCFA ID: 7985E

State: Hawaii

Standards for Optional State Supplementary Payments

Payment Category (Reasonable Classification)	Administered by		Income Level				Income Disregards Employed
	Federal	State	Gross*		Net**		
			1 person	Couple	1 person	Couple	
(1) A, B, D IN DOMICILIARY CARE: LEVEL I	(2)	X	(3)	(4)			(5)
	\$733.00	\$651.90	\$2,199.00	N/A	\$1,384.90	N/A	
LEVEL II	\$733.00	\$759.90	\$2,199.00	N/A	\$1,492.90	N/A	

NOTE: \*Gross income, before deductions allowed by SSI, cannot exceed 300% of the FBR.  
 \*\*Net income, after deductions allowed by SSI, cannot exceed the SSI/SSP payment limit

TN No. 15-001 Approval Date: 03/12/15 Effective Date: 01/01/2015  
 Supersedes TN No. 14-001

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

SUPPLEMENT 7 TO ATTACHMENT 2.6  
Page 1  
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

INCOME LEVELS FOR 1902(?) STATES - CATEGORICALLY NEEDY  
WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

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TN No. 91-21  
Supersedes 89-7 Approval Date 10/13/92 Effective Date 10/01/91  
TN No. 89-7 HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

RESOURCE STANDARDS FOR 1902(f) STATES - CATEGORICALLY NEEDY

Same as the medically needy

<u>Family Size</u>	<u>Resource Level</u>
1	\$2,000
2	3,000

For each additional person, add \$250 to the resource level for 2 persons.

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TN No. 91-21  
Supersedes \_\_\_\_\_ Approval Date 10/13/92 Effective Date 10/01/91  
TN No. \_\_\_\_\_ HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

MORE LIBERAL METHODS OF TREATING INCOME  
UNDER SECTION 1902(r)(2) OF THE ACT

Section 1902(f) State  Non-Section 1902(f) State

1. For optional targeted low income children covered under 1902(a)(10)(A)(ii)(XIV) of the Act subject to 1902(r)(2):

Disregard the difference in countable income between 300% of the Federal Poverty Level (FPL) and 250% FPL for optional targeted low income children covered under 1902(a)(10)(A)(ii)(XIV) of the Act.

2. Wages paid by the Census Bureau for temporary employment related to census activities are excluded for the eligibility groups:

**Mandatory Categorically Needy Eligibility Groups**

- |  |   |
|--|---|
| 1. Children no longer eligible for SSI because of change in definition of disability.        | §1902(a)(10)(A)(i)(II)                  |
| 2. Qualified pregnant women.   | §1902(a)(10)(A)(i)(III), §1905(n)(1)    |
| 3. Qualified children.   | §1902(a)(10)(A)(i)(III), §1905(n)(2)    |
| 4. Poverty level pregnant women.   | §1902(a)(10)(A)(i)(IV), §1902(l)(1)(A)  |
| 5. Poverty level infants.  | §1902(a)(10)(A)(i)(IV), §1902(l)(1)(B)  |
| 6. Poverty level children under age 6.   | §1902(a)(10)(A)(i)(VI), §1902(l)(1)(C)  |
| 7. Poverty level children under age 19.  | §1902(a)(10)(A)(i)(VII), §1902(l)(1)(D) |
| 8. Disabled individual whose earnings exceed SSI substantial gainful activity level.         | §1619(a)                                |
| 9. Disabled individual whose earnings are too high to receive SSI cash benefit.              | §1619(b)                                |
| 10. Disabled individual whose earnings are too high to receive SSI cash benefit.             | §1902(a)(10)(A)(i)(II), §1905(q)        |
| 11. Pickle amendment -Would be eligible for SSI if title II COLAs were deducted from income. | Section 503 of P.L. 94-566              |
| 12. Disabled widows/widowers.  | §1634(b), §1935                         |
| 13. Disabled adult children.   | §1634(c), §1935                         |
| 14. Early widows/widowers.   | §1634(d), §1935                         |
| 15. Qualified Disabled and Working Individuals.  | §1902(a)(10)(E)(ii), §1905(s)           |
| 16. Qualified Medicare Beneficiaries.  | §1902(a)(10)(E)(i), §1905(p)(1)         |
| 17. Specified Low Income Beneficiaries.  | §1902(a)(10)(E)(iii)                    |

TN No. 08-017

Supersedes

TN No. 08-004

Approval Date: **FEB 13 2009**

Effective Date: 10/01/2008



18. Qualified Individuals -I. §1902(a)(10)(E)(iv)(I)  
**Optional Categorically Needy Eligibility Groups**
1. Meet the income and resource requirements of the appropriate cash assistance program (SSI or AFDC). §1902(a)(10)(A)(ii)(I)
  2. Would meet the income and resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency. §1902(a)(10)(A)(ii)(II)
  3. Would be eligible for cash assistance (AFDC or SSI) if they were not in a medical institution. Receiving, or would be eligible to receive if they were not in a medical institution, a State supplement payment. §1902(a)(10)(A)(ii)(IV)
  4. Individuals under age 21 who are under State adoption agreements. §1902(a)(10)(A)(ii)(VIII)
  5. Aged or disabled individuals with income that does not exceed 100 percent of the Federal poverty level. §1902(a)(10)(A)(ii)(X)
  6. Receiving only an optional State supplement which is more restrictive than the criteria for an optional State supplement under title XVI. §1902(a)(10)(A)(ii)(XI)
  7. Optional targeted low income children. §1902(a)(10)(A)(ii)(XIV)
  8. Medically Needy. §1902(a)(10)(C), §1902(a)(10)(C)(i)(III)

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10/01/2008

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT

3. For children under Section 1902(a)(10)(i)(VII) and 1902(1)(1)(D) of the Act (children who were born after September 30, 1983 and have attained age 6 but have not attained age 19), subject to 1902(r)(2):

Disregard the difference in countable income between 133% of the Federal Poverty Level (FPL) and 100% FPL for children covered under Sections 1902(a)(10)(i)(VII) and 1902(1)(1)(D) of the Act.

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TN No.	<u>13-010</u>	Approval Date:	<u>02/12/2014</u>	Effective Date:	<u>10/01/2013</u>
Supersedes					
TN No.	<u>NEW</u>				

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT

4. Disregard all income for 2101(f)-like reasonable classification of children described in Supplement 1 to Attachment 2.2-A, page 2.

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TN No.	<u>13-011</u>	Approval Date:	<u>03/13/2014</u>	Effective Date:	<u>12/31/2013</u>
Supersedes					
TN No.	<u>NEW</u>				

*HK REMOVE*

Revision: HCFA-PM-91-4  
August 1991

(BPD)

SUPPLEMENT 8a to ATTACHMENT 2.1-A

Page 1

OMB No.: 0938

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

MORE LIBERAL METHODS OF TREATING INCOME  
UNDER SECTION 1902 (f) (2) OF THE ACT\*

Section 1902 (f) State

Non-Section 1902 (f) State

\* More liberal methods may not result in exceeding gross income limitations under section 1903(f).

TN No. 00-006  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

Approval Date: JUL 11 2000 Effective Date: APR 1 2000

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

MORE LIBERAL METHODS OF TREATING  
RESOURCES UNDER SECTION 1902(r)(2) OF THE ACT

Section 1902(f) State

Non-Section 1902(f) State

For all ABD groups:

1. The equity value of all motor vehicles such as cars, trucks, vans, campers, motorcycles, and mobile homes are exempt from consideration toward the personal reserve, regardless of the value or the use of the vehicles, with the exception of all watercrafts and air transportation vehicles, such as boats, airplanes, and helicopters that will continue to be considered toward the personal reserve.

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TN No. 13-004b  
Supersedes 03-001 Approval Date: 09/30/2013 Effective Date: 01/01/2014

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

TRANSFER OF RESOURCES

1902(f) and 1917  
of the Act

The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value.

A. Except as noted below, the criteria for determining the period of ineligibility are the same as criteria specified in section 1613(c) of the Social Security Act (Act).

1. Transfer of resources other than the home of an individual who is an inpatient in a medical institution.

a.  The agency uses a procedure which provides for a total period of ineligibility greater than 24 months for individuals who have transferred resources for less than fair market value when the uncompensated value of disposed of resources exceeds \$12,000. This period bears a reasonable relationship to the uncompensated value of the transfer. The computation of the period and the reasonable relationship of this period to the uncompensated value is described as follows:

TN No. 91-21  
Supersedes  
TN No. 85-5

Approval Date 10/13/92

Effective Date 10/01/91

HCFA ID: 7985E

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AUGUST 1991

SUPPLEMENT 9 TO ATTACHMENT 2.6-A  
Page 2  
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

b.  The period of ineligibility is less than 24 months, as specified below:

c.  The agency has provisions for waiver of denial of eligibility in any instance where the State determines that a denial would work an undue hardship.

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TN No. 91-21 Approval Date 10/13/92 Effective Date 10/01/91  
Supersedes  
TN No. 85-5 HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

2. Transfer of the home of an individual who is an inpatient in a medical institution.

A period of ineligibility applies to inpatients in an SNF, ICF or other medical institution as permitted under section 1917(c)(2)(B)(i).

- a. Subject to the exceptions on page 2 of this supplement, an individual is ineligible for 24 months after the date on which he disposed of the home. However, if the uncompensated value of the home is less than the average amount payable under this plan for 24 months of care in an SNF, the period of ineligibility is a shorter time, bearing a reasonable relationship (based on the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

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Supersedes  
TN No. 85-5  
HCFA ID: 7985E



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

- b.  Subject to the exceptions on page 2 of this supplement, if the uncompensated value of the home is more than the average amount payable under this plan as medical assistance for 24 months of care in an SNF, the period of ineligibility is more than 24 months after the date on which he disposed of the home. The period of ineligibility bears a reasonable relationship (based upon the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

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Supersedes  
TN No. 85-5 HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

No individual is ineligible by reason of item A.2 if--

- (i) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home;
- (ii) Title to the home was transferred to the individual's spouse or child who is under age 21, or (for States eligible to participate in the State program under title XVI of the Social Security Act) is blind or permanently and totally disabled or (for States not eligible to participate in the State program under title XVI of the Social Security Act) is blind or disabled as defined in section 1614 of the Act;
- (iii) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual intended to dispose of the home either at fair market value or for other valuable consideration; or
- (iv) The agency determines that denial of eligibility would work an undue hardship.

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TN No. 91-21 Approval Date 10/192 Effective Date 10/01/91  
Supersedes  
TN No. 85-5 HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

3. 1902(f) States

Under the provisions of section 1902(f) of the Social Security Act, the following transfer of resource criteria more restrictive than those established under section 1917(c) of the Act, apply:

B. Other than those procedures specified elsewhere in the supplement, the procedures for implementing denial of eligibility by reason of disposal of resources for less than fair market value are as follows:

1. If the uncompensated value of the transfer is \$12,000 or less:

2. If the uncompensated value of the transfer is more than \$12,000:

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TN No. 91-21 Approval Date 10/13/92 Effective Date 10/01/91  
Supersedes  
TN No. 85-5 HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

3. If the agency sets a period of ineligibility of less than 24 months and applies it to all transfers of resources (regardless of uncompensated value):

4. Other procedures:

An institutionalized spouse who (or whose spouse) transferred resources for less than fair market value shall not be found ineligible for nursing facility services, for a level of care in a medical institution equivalent to that of nursing facility services, or for home and community-based services where the State determines that denial of eligibility would work an undue hardship under the provision of Section 1917(c)(2)(D) of the Social Security Act.

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TN No. 91-21  
Supersedes 90-16 Approval Date 10/13/92 Effective Date 10/01/91  
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: HAWAII

TRANSFER OF RESOURCES

Section  
1917(c)  
of the  
Act

(1) The agency provides for a period of ineligibility for nursing facility services and for a level of care in a medical institution equivalent to that of nursing facility services and for services under Section 1915(c) of the Act in the case of an institutionalized individual (as defined in item (3), on page 3 of this Addendum to Supplement 9 to Attachment 2.6-A) who, or whose spouse, transfers resources (as defined in item (4), on page 3 of this Addendum to Supplement 9 to Attachment 2.6-A) for less than fair market value at any time during or after the 30-month period immediately before the date the individual becomes an institutionalized individual or, if later, the date the institutionalized individual applies for medical assistance.

Except as provided in item (2), on page 2 and 3 of this Addendum to Supplement 9 to Attachment 2.6-A, the period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to the lesser of-

- (A) 30 months, or
- (B) the total uncompensated value of the resources so transferred, divided by the average cost, to a private patient at the time of the application, of nursing facility services in the State.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: HAWAII

(2) An individual shall not be ineligible for medical assistance by reason of a transfer (as provided on page 1 of this Addendum to Supplement 9 to Attachment 2.6-A) to the extent that -

- (A) the resources transferred were a home and title to the home was transferred to -
  - (i) the spouse of such individual;
  - (ii) a child of such individual who is under age 21 or is blind or disabled as defined in Section 1614 of the Act;
  - (iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or
  - (iv) a son or daughter of such individual (other than a child described in item (2) (A) (ii) above) who was residing in such individual's home for a period of at least 2 years immediately before the date the individual becomes an institutionalized individuals, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;
- (B) the resources were transferred-
  - (i) to or from (or to another for the sole benefit of) the individual's spouse, or
  - (ii) to the individual's child described in item (2) (A) (ii), above;
- (C) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that-
  - (i) the individual intended to dispose of the resources either at fair market value, or for other valuable consideration; or
  - (ii) the resources were transferred exclusively for a purpose other than to qualify for medical assistance; or
- (D) the State determines that denial of eligibility would work an undue hardship, under the provisions of Section 1917(c) (2) (D) of the Social Security Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: HAWAII

(3) For purposes of Section 1917(c) of the Act, the term "institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in Section 1902(a)(10)(A)(ii)(VI) of the Act.

(4) The State will not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with subsection 1917(c) of the Act.

(5) For purposes of Section 1917(c) of the Act, the term "resources" has the meaning given such term in Section 1613 of the Act, without regard to the exclusion described in subsection (a)(1) thereof.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State: HAWAII

**TRANSFER OF ASSETS**

1917(c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency withholds payment to institutionalized individuals for the following services:

Payments based on a level of care in a nursing facility;

Payments based on a nursing facility level of care in a medical institution;

Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

— The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled and elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

— The following other long-term care services for which medical assistance is otherwise under the agency plan:



State: HAWAII

**TRANSFER OF ASSETS**

3. **Penalty Date**—The beginning date of each penalty period imposed for an uncompensated transfer of assets is:
- the first day of the month in which the asset was transferred;
- the first day of the month following the month of transfer.
4. **Penalty Period - Institutionalized Individuals**—  
In determining the penalty for an institutionalized individual, the agency uses:
- the average monthly cost to a private patient of nursing facility services in the agency;
- the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.
5. **Penalty Period - Non-institutionalized Individuals**—  
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;
- imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

State: HAWAII

TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care--
- a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:
- X does not impose a penalty;
- imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.
- b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:
- X does not impose a penalty;
- imposes a series of penalties, each for less than a full month.
7. Transfers made so that penalty periods would overlap--  
The agency:
- totals the value of all assets transferred to produce a single penalty period;
- X calculates the individual penalty periods and imposes them sequentially.
8. Transfers made so that penalty periods would not overlap--  
The agency:
- X assigns each transfer its own penalty period;
- uses the method outlined below:

State: \_\_\_\_\_

**TRANSFER OF ASSETS**

9. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

- (a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

When both spouses are eligible for Medicaid and both spouses are institutionalized, the State will use the following method to apportion the penalty period:

- \* Apportion the penalty period equally between the spouses;
- \* If one spouse dies or leaves the institution prior to the expiration of their share of the penalty period, the remainder of the penalty will be assigned to the spouse who is still institutionalized;
- \* The penalty months served by the institutionalized spouses shall not exceed the length of the original penalty period.

- (b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset--

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

\_\_\_ The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

\_\_\_ For transfers of individual income payments, the agency will impose partial month penalty periods.

X For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

\_\_\_ The agency uses an alternate method to calculate penalty periods, as described below:

State: HAWAII

**TRANSFER OF ASSETS**

11. Imposition of a penalty would work an undue hardship--  
The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:
- a) Notify the individuals subject to the transfer of assets penalty that there are exceptions to the transfer of assets penalty due to undue hardship.
  - b) If a waiver for undue hardship is requested, the individual seeking the waiver must provide documentation of efforts taken to recover the transferred asset.
  - c) Individuals will be notified of the disposition of their request for a waiver of the transfer of asset penalty. Individuals who are denied the waiver must be informed of their right to a fair hearing.

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

- a) The recoverable amount of the transferred asset is depleted below State resource standard; or
- b) The transferred asset has been converted to another asset that is not liquid or redeemable; or
- c) The return of the transferred property would put the receiving party in serious risk of deprivation such as the loss of income or assets that would qualify the receiver for medical assistance; or
- d) Unable to locate the receiving party of the transferred asset after exhaustive search efforts.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

TRANSFER OF ASSETS

1917(c) **FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006, the agency provides for the denial of certain Medicaid services.**

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the lookback date.

The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

- Nursing facility services;
- Nursing facility level of care provided in a medical institution;
- Home and community-based services under a 1915(c) or (d) waiver.

2. Non-institutionalized individuals:

\_\_\_\_\_ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

- Home health services (section 1905(a)(7));
- Home & community care for functionally disabled elderly adults (section 1905(a)(22));
- Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

\_\_\_\_\_ The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

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Supersedes

TN No. NEW

Approval Date: SEP 7 2010 Effective Date: 10/01/09

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

TRANSFER OF ASSETS (cont.)

3. Penalty Date—The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

- For individuals applying for Medicaid payment of long-term care services, the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level of care services described in paragraph 1 that, were it not for the imposition of the penalty period, would be covered by Medicaid (based on an approved application for such care);

or

- For individuals receiving Medicaid payment for long-term care services, the first day of the month following timely advance notice of the penalty period.

and

- Which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

4. Penalty Period - Institutionalized Individuals

In determining the penalty for an institutionalized individual, the agency uses:

- The average monthly cost to a private patient of nursing facility services in the State at the time of application;
- The average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

5. Penalty Period - Non-institutionalized Individuals

The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services:

- Imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

TRANSFER OF ASSETS (cont.)

6. Penalty period for amounts of transfer less than cost of nursing facility care

X Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.

X The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

7. Penalty periods - transfer by a spouse that results in a penalty period for the individual

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

When both spouses are eligible for long-term care services, the State will use the following method to apportion the penalty period:

- Apportion the penalty period equally between the spouses;
- If one spouse dies or no longer requires long-term care services prior to the expiration of their share of the penalty period, the remainder of the penalty period will be assigned to the spouse who is still receiving long-term care services;
- The penalty months served by the institutionalized spouses shall not exceed the length of the original penalty period.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

TRANSFER OF ASSETS (cont.)

8. Treatment of a transfer of income

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred as described below.

The agency will consider the amount of income expected to be received during the individual's lifetime when the right to receive a stream of income was transferred. The total amount of income is calculated by multiplying the annual amount of income by the individual's life expectancy based on the life expectancy tables established by the Social Security Administration's Office of the Actuary.

9. Imposition of a penalty for an undue hardship

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would deprive the individual of:

- (a) Medical care such that the individual's health or life would be endangered; or
- (b) Food, clothing, shelter, or other necessities of life.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

TRANSFER OF ASSETS (cont.)

10. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

- (a) Notice to a recipient subject to a penalty that an undue hardship exception exists;
- (b) A timely process for determining whether an undue hardship waiver will be granted; and
- (c) A process, which is described in the notice, under which an adverse determination can be appealed.

The procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.

11. Bed Hold Waivers for Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

\_\_\_\_\_ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed \_\_\_\_\_ days (may not be greater than 30).

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10/01/09

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship.

The following criteria will be used to determine whether the agency will not count assets transferred because doing so would work an undue hardship:

- a) The maximum distribution from the trust in addition to other available income and assets of the individual is less than the State's eligibility standards for income and resources; or
- b) There are legal actions that prevent the distributions of funds to the medical and basic needs of the individual; and
- c) The individual has taken legal action to recover the funds placed in trust.

Under the agency's undue hardship provisions, the agency exempts the funds in an irrevocable burial trust.

The maximum value of the exemption for an irrevocable burial trust is \$\_\_\_\_\_.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HawaiiMETHODS FOR TREATMENT OF RESOURCES THAT ARE  
MORE LIBERAL THAN SSI

The following more liberal methods apply to all medical assistance groups except recipients of AFDC and SSI and persons deemed, for purposes of Title XIX, to be receiving AFDC or SSI. Deemed AFDC recipients are defined in item A.2, on pages 1 and 2 of Attachment 2.2-A of the Hawaii State Plan (also see 42 C.F.R. 435.115). Deemed SSI recipients include persons eligible under 42 C.F.R. 435.135 (the Pickle amendment); persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act; disabled widow(er)s eligible for Medicaid under section 1634(b) of the Act; disabled children eligible under section 1634(c) of the Act; and early aged widow(er)s eligible under section 1634(d) of the Act.

1. Basic maintenance items essential to day-to-day living such as clothing, furniture, stove, etc., shall be disregarded without regard to the value of the items.

TN No. 90-8

Supersedes

Approval Date 11/12/90 Effective Date 7/1/90

TN No. \_\_\_\_\_

HCFA ID: 4093E/0002P

Revision: HCFA-PM-97-2  
December 1997

12a  
SUPPLEMENT ~~TO~~ TO  
ATTACHMENT 2.6-A  
Page 1  
OMB No.:0938-0673

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

*NONE*

TN No. 98-003  
Supersedes  
TN No

Approval Date 12/11/98

Effective Date 10/1/98

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

SECTION 1924 PROVISIONS

- A. Income and resource eligibility policies used to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with Section 1924.
- B. In the determination of resource eligibility the State resource standard is the maximum allowed by federal statute or regulations with provisions for increase, as allowed by the Secretary of Health and Human Services by means of indexing court order or fair hearing.
- C. An institutionalized spouse who (or whose spouse) has excess resources shall not be found ineligible under title XIX of the Social Security Act, per Section 1924(c)(3)(C), where the State determines that denial of eligibility on the basis of having excess resources would work an undue hardship.

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TN No.. 90-16  
Supersedes  
TN No. 89-10

Approval Date 3/1/91

Effective Date 10/1/90

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

ASSET VERIFICATION SYSTEM

- 1940(a) 1. The Agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements:
- A. The request and response system must be electronic:
    - (1) Verification inquiries must be sent electronically via the internet or similar means from the Agency to the financial institution (FI).
    - (2) The system cannot be based on mailing paper-based requests.
    - (3) The system must have the capability to accept responses electronically.
  - B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).
  - C. The system must establish and maintain a database of FIs that participate in the Agency's AVS.
  - D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the Agency determines that such requests are needed to determine or redetermine the individual's eligibility.
  - E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years.

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TN No. 11-001  
Supersedes  
TN No. NEW

Approval Date: MAY 05 2011 Effective Date: September 30, 2011

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

ASSET VERIFICATION SYSTEM

2. System Development

A.  The Agency itself will build and maintain an AVS.

In 3 below, describe how the system will meet the requirements in Section 1.

B.  The Agency will hire a contractor to build and maintain an AVS.

In 3 below, identify the contractor, if known, and describe how the system will meet the requirements in Section 1.

C.  The Agency will be joining a consortium to develop an AVS.

In 3 below, identify the States participating in the consortium. Also identify the contractor, if known, who will build and maintain the consortium's AVS, and how the system will meet the requirements in Section 1.

D.  The Agency already has a system in place that meets the requirements for an acceptable AVS:

In 3 below, describe how the system meets the requirements in Section 1.

E.  Other alternative not included in A. – D. above.

In 3 below, describe this alternative approach how it will meet the requirements in Section 1.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

ASSET VERIFICATION SYSTEM

3. Provide the AVS implementation description and other information requested for the implementation approach checked in Section 2.

A Request For Proposal (RFP) shall be issued to solicit participation by qualified contractors to design, develop, implement and operationalize an Asset Verification System (AVS) for purposes of determining Medicaid eligibility for aged, blind, and disabled Medicaid applicants and recipients as required under 1940 of the Social Security Act.

The AVS shall meet the requirements in Section 1 of Supplement 16 to attachment 2.6-A of the State Plan securing authorization from the applicant or recipient (and such other person, as applicable) at no cost.

The contractor shall provide the State with data reports; such as, but not limited to the following:

- a. Number of verification requests;
- b. Number of responses provided;
- c. Amount of undisclosed assets discovered; and
- d. Any other data reports necessary to meet federal reporting requirements.

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TN No. 11-001  
Supersedes  
TN No. NEW

Approval Date: MAY 05 2011 Effective Date: September 30, 2011



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

**DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH  
SUBSTANTIAL HOME EQUITY**

1917(f)

The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State Plan for an individual who does not have a spouse, child under 21, or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

\$500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest \$1,000).

An amount that exceeds \$500,000 but does not exceed \$750,000 (increased by the annual percentage increase in urban component of the consumer price index beginning with 2011, rounded to the nearest \$1,000).

The amount chosen by the State is \$750,000

This higher standard applies statewide.

This higher standard does not apply statewide. It only applies in the following areas of the State:

This higher standard applies to all eligibility groups.

This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.

TN No. 09-011  
Supersedes  
TN No. NEW

Approval Date: SEP 1 2010 Effective Date: 10/01/09

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

**METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES**

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

**Part 1 - Adult Group Individual Income-Based Determinations**

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on 03/31/2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

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TN No.	<u>14-002</u>	Approval Date:	<u>05/16/2014</u>	Effective Date:	<u>01/01/2014</u>
Supersedes					
TN No.	<u>NEW</u>				

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Population Group	Relevant Population Group Income Standard For each population group, indicate the lower of:  <ul style="list-style-type: none"> <li>The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or 133% FPL.</li> <li>If a population group was not covered as of 12/1/09, enter "Not covered".</li> </ul>	Applicable Population Adjustment				
		Resource Proxy	Enrollment Cap	Special Circumstances	Other Adjustments	
<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>	
Parents/Caretaker Relatives	Attachment A, column C, Line 1 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	No	No	No	
Disabled Persons, non-institutionalized	Attachment A, column C, Line 2 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	No	No	No	
Disabled Persons, institutionalized	Attachment A, column C, Line 3 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	No	No	No	
Children Age 19 or 20	NA	NA	NA	NA	NA	
Childless Adults	Attachment A, column C, Line 5 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	Yes	No	No	

TN No. 14-002 Approval Date: 05/16/2014 Effective Date: 01/01/2014  
 Supersedes \_\_\_\_\_  
 TN No. NEW

**Part 2 - Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances**

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

- Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.
- Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B)

Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

The state:

- Applies existing state data from periods before January 1, 2014.
- Applies data obtained through a post-eligibility statistically valid sample of individuals.

Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1.  An enrollment cap adjustment is applied (complete items 2 through 4).
- An enrollment cap adjustment is not applied (skip items 2 through 4 and go to Section C).

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2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).
3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:
- Yes. The combined enrollment cap adjustment is described in Attachment C.
- No.
4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:
- Applies special circumstances adjustment(s).
- Does not apply a special circumstances adjustment.
2. The state:
- Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).
- Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).
3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

<b>TN No.</b>	<u>14-002</u>	<b>Approval Date:</b>	<u>05/16/2014</u>	<b>Effective Date:</b>	<u>01/01/2014</u>
<b>Supersedes</b>					
<b>TN No.</b>	<u>NEW</u>				

**Part 3 - One-Time Transitions of Previously Covered Populations into the New Adult Group**

- A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group
- Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.
  - The state does not have any relevant populations requiring such transitions.

**Part 4 - Applicability of Special FMAP Rates**

A. Expansion State Designation

The state:

- Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)
- Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated 1/23/2014.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

- Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).
- Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated (insert date). The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

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**Part 5 - State Attestations**

The State attests to the following:

- A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.
- B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

**ATTACHMENTS**

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- Attachment A - Conversion Plan Standards Referenced in Table 1
- Attachment B - Resource Criteria Proxy Methodology
- Attachment C - Enrollment Cap Methodology
- Attachment D - Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- Attachment E - Transition Methodologies

**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 4 hours per response, including the time to review instructions, searching existing data resources, gather data needed, and completed and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

<b>TN No.</b>	<u>14-002</u>			
<b>Supersedes</b>		<b>Approval Date:</b>	<u>05/16/2014</u>	<b>Effective Date:</b> <u>01/01/2014</u>
<b>TN No.</b>	<u>NEW</u>			

Most Recent Updated Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan\*

HAWAII

02/28/2014

Conversions for FMAP Claiming Purposes					
A	B	C	D	E	F
Population Group	Net standard as of 12/1/09	Converted standard for FMAP claiming	Same as converted eligibility standard? (yes, no, or n/a)	Source of information in Column C (New SIPP conversion or Part 1 of approved state MAGI conversion plan)	Data source for Conversion (SIPP or state data)
1 Parents/Caretaker Relatives FPL %	100%	100%	Yes	Part 1 of approved state MAGI conversion plan	SIPP
2 Non-institutionalized Disabled Persons FPL %	100%	100%	n/a	new SIPP conversion	SIPP
3 Institutionalized Disabled Persons FPL %	100%	100%	n/a	new SIPP conversion	SIPP
4 Children Age 19-20	n/a	n/a	n/a	n/a	n/a
5 Childless Adults FPL %	100%	100%	Yes	Part 1 of approved State MAGI conversion plan	SIPP

n/a: Not applicable.

\*The numbers in this summary chart will be updated automatically in the case of modification in the CMS approved MAGI conversion plan.

TN No.

14-002

Supersedes

Approval Date:

05/16/2014

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01/01/2014

TN No.

NEW



Methodology For Identification For Applicable FMAP Rates. Refer to the January 23, 2014 correspondence between the State and CMS confirming the FMAP rates for our adult population, confirmation of expansion state status, and the enrollment cap for childless adults.

The federal medical assistance percentages (FMAP) percentages for individuals in the Adults Group shall be determined as follows:

- 1) Monthly capitation payment files (RP 250) are produced by the 5<sup>th</sup> working day of each month. The monthly files contain payment and member month information for those enrolled during that month and retroactive payments from any previous month.
- 2) On 12/1/09 the baseline enrollment for the childless adults was 27,265. To calculate the percentage of expenditures that should be charged to the newly eligible populations (100% FMAP) Hawaii will extract all members with Eligibility Code (elg cd) equal to "A42". Code A42 is assigned by the eligibility system as childless adults with a FPL not to exceed 100%.
- 3) A count of member months will be totaled for each month during the quarter. A member month is defined as any member enrolled for any period during that month. If a member is enrolled during a partial month it is counted as one member month.
- 4) The following are examples of how calculations will be completed.

Expenditures for the childless adult population will include capitation payments and non-capitation payments including transplant services, behavioral health services, and fee for service payments not included in the capitation rates.

January 2014-25,000  
February 2014-26,000  
March 2014-27,000

Avg. Member Months for QTE 3/31/14-78,000/3=26,000

$27265/26000=105\%$  but capped at 100%

Expenditures-\$50,000,000

\$50,000,000 or 100% of the expenditures for childless adults will be charged to the transitional FMAP rate of 75.93%

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TN No.	<u>14-002</u>	Approval Date:	<u>05/16/2014</u>	Effective Date:	<u>01/01/2014</u>
Supersedes					
TN No.	<u>NEW</u>				

April 2014-30,000  
May 2014-35,000  
June 2014-40,000

Avg. Member Months for QTE 6/30/14-105,000/3=35,000

27,265/35000=77.9%

Expenditures \$60,000,000

46,740,000 or 77.9% of the expenditures will be charged to the newly eligible group at the transitional FMAP rate of 75.93% and \$13,260,000 or 22.10% will be charged to the newly eligible population at 100% FMAP.

- 5) The quarterly average member month data and baseline number will be submitted to CMS by the first of each month following the end of the quarter to load into the MBES system. The information will be emailed to CMS Central Office and to CMS Regional Office.

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TN No.	<u>14-002</u>	Approval Date:	<u>05/16/2014</u>	Effective Date:	<u>01/01/2014</u>
Supersedes					
TN No.	<u>NEW</u>				

Hawaii QUEST Expanded Medicaid - Demonstration Transition Plan Addendum

**A. Coverage in 2014**

1. The state does not intend to make any reductions to state plan eligibility for January 1, 2014. State plan beneficiaries will not have to take any action outside of the standard redetermination process.
2. The state will be delaying redetermination through March 31, 2014.
3. The state will transfer approximately 30,000-40,000 adults below 138 percent of federal poverty level (FPL) from the demonstration into the new adult group. This transition will require no action on the part of the beneficiary outside of the standard redetermination process.

**B. Process for Transition**

1. Per the approved demonstration, Hawaii expanded coverage effective October 1, 2013. The January 1, 2014 transition of demonstration beneficiaries to the Medicaid state plan will be seamless from the perspective of the beneficiary.
2. The state's new eligibility and enrollment system went live on October 1, 2013. During the last week of September, the state conducted a mass conversion of data from the old system to the new system. This involved a crosswalk between the systems, migration of the data, and then a conversion to the new coding.
3. The state is currently using prepopulated renewal forms and will continue to use them in the future.
4. The state will collect the additional information necessary for a Modified Adjusted Gross Income (MAGI) determination at the beneficiary's redetermination, beginning April 2014.
5. Hawaii checks an individual for all Medicaid eligibility categories prior to terminating the individual from the Medicaid or demonstration program.

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TN No. 14-002  
Supersedes \_\_\_\_\_ Approval Date: 05/16/2014 Effective Date: 01/01/2014  
TN No. NEW

6. Hawaii operates a State-based Marketplace (SBM). The Medicaid and SBM are separate entities. All applications for financial assistance are sent first to the Medicaid program, where individuals are screened for Medicaid eligibility. If the beneficiary is determined ineligible for Medicaid, the state will send all of the beneficiary's information electronically to the SBM. The SBM will then make an eligibility determination of for the Advanced Premium Tax Credit (APTC).

**C. Notification Process/Notices**

1. The state sent notices in both August and September 2013 to current beneficiaries informing them of the upcoming changes in eligibility and expansion program.
2. The state's Alternative Benefit Plan (ABP) has not yet been approved; however, Hawaii does not expect the approval of the ABP to result in any benefit changes for beneficiaries.
3. Hawaii does not intend to send any additional notices to beneficiaries moving from the demonstration to the state plan. Since this process will be seamless and not involve any change to benefits, the state feels that additional noticing would only create confusion about a process that will be seamless to the beneficiary.

**D. Community Outreach**

1. The SBM received level II grants to help inform people about the Marketplace. The state is marketing its SBM and Medicaid program as a continuum of "help with health insurance".
2. The SBM has substantial outreach efforts to encourage people to apply. The SBM is working with navigators.
3. The state has advertisements in the community about the new healthcare options and expansion.

<b>TN No.</b>	<u>14-002</u>	<b>Approval Date:</b>	<u>05/16/2014</u>	<b>Effective Date:</b>	<u>01/01/2014</u>
<b>Supersedes</b>					
<b>TN No.</b>	<u>NEW</u>				

**SUPERSEDING PAGES OF  
STATE PLAN MATERIAL**

**TRANSMITTAL NUMBER:**

13-0007-MM5

**STATE:**

Hawaii

**PAGE NUMBER OF THE PLAN SECTION OR  
ATTACHMENT:**

S88 Non-Financial Eligibility- State Residency

**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (*If Applicable*):**

Section 2.3: Page 13, TN 87-4  
Attachment 2.6-A: Page 3, TN 13-0007 MM6



# Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

42 CFR 435.403

## State Residency

- The state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

Individuals are considered to be residents of the state under the following conditions:

- Non-institutionalized individuals age 21 and over, or under age 21, capable of indicating intent and who are emancipated or married, if the individual is living in the state and:
  - Intends to reside in the state, including without a fixed address, or
  - Entered the state with a job commitment or seeking employment, whether or not currently employed.
- Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.
- Non-institutionalized individuals under 21 not described above and non IV-E beneficiary children:
  - Residing in the state, with or without a fixed address, or
  - The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.
- Individuals living in institutions, as defined in 42 CFR 435.1010, including foster care homes, who became incapable of indicating intent before age 21 and individuals under age 21 who are not emancipated or married:
  - Regardless of which state the individual resides, if the parent or guardian applying for Medicaid on the individual's behalf resides in the state, or
  - Regardless of which state the individual resides, if the parent or guardian resides in the state at the time of the individual's placement, or
  - If the individual applying for Medicaid on the individual's behalf resides in the state and the parental rights of the institutionalized individual's parent(s) were terminated and no guardian has been appointed and the individual is institutionalized in the state.
- Individuals living in institutions who became incapable of indicating intent at or after age 21, if physically present in the state, unless another state made the placement.
- Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.
- Any other institutionalized individual age 21 or over when living in the state with the intent to reside there, and not placed in the institution by another state.
- IV-E eligible children living in the state, or



## Medicaid Eligibility

Otherwise meet the requirements of 42 CFR 435.403.



# Medicaid Eligibility

Meet the criteria specified in an interstate agreement.

Yes  No

The state has interstate agreements with the following selected states:

- |  |   |  |  |
|--|---|--|--|
| <input checked="" type="checkbox"/> Alabama              | <input checked="" type="checkbox"/> Illinois      | <input checked="" type="checkbox"/> Montana        | <input checked="" type="checkbox"/> Rhode Island   |
| <input checked="" type="checkbox"/> Alaska               | <input checked="" type="checkbox"/> Indiana       | <input checked="" type="checkbox"/> Nebraska       | <input checked="" type="checkbox"/> South Carolina |
| <input checked="" type="checkbox"/> Arizona              | <input checked="" type="checkbox"/> Iowa          | <input checked="" type="checkbox"/> Nevada         | <input checked="" type="checkbox"/> South Dakota   |
| <input checked="" type="checkbox"/> Arkansas             | <input checked="" type="checkbox"/> Kansas        | <input checked="" type="checkbox"/> New Hampshire  | <input checked="" type="checkbox"/> Tennessee      |
| <input checked="" type="checkbox"/> California           | <input checked="" type="checkbox"/> Kentucky      | <input checked="" type="checkbox"/> New Jersey     | <input checked="" type="checkbox"/> Texas          |
| <input checked="" type="checkbox"/> Colorado             | <input checked="" type="checkbox"/> Louisiana     | <input checked="" type="checkbox"/> New Mexico     | <input checked="" type="checkbox"/> Utah           |
| <input checked="" type="checkbox"/> Connecticut          | <input checked="" type="checkbox"/> Maine         | <input checked="" type="checkbox"/> New York       | <input checked="" type="checkbox"/> Vermont        |
| <input checked="" type="checkbox"/> Delaware             | <input checked="" type="checkbox"/> Maryland      | <input checked="" type="checkbox"/> North Carolina | <input checked="" type="checkbox"/> Virginia       |
| <input checked="" type="checkbox"/> District of Columbia | <input checked="" type="checkbox"/> Massachusetts | <input checked="" type="checkbox"/> North Dakota   | <input checked="" type="checkbox"/> Washington     |
| <input checked="" type="checkbox"/> Florida              | <input checked="" type="checkbox"/> Michigan      | <input checked="" type="checkbox"/> Ohio           | <input checked="" type="checkbox"/> West Virginia  |
| <input checked="" type="checkbox"/> Georgia              | <input checked="" type="checkbox"/> Minnesota     | <input checked="" type="checkbox"/> Oklahoma       | <input checked="" type="checkbox"/> Wisconsin      |
| <input checked="" type="checkbox"/> Hawaii               | <input checked="" type="checkbox"/> Mississippi   | <input checked="" type="checkbox"/> Oregon         | <input checked="" type="checkbox"/> Wyoming        |
| <input checked="" type="checkbox"/> Idaho                | <input checked="" type="checkbox"/> Missouri      | <input checked="" type="checkbox"/> Pennsylvania   |  |

The interstate agreement contains a procedure for providing Medicaid to individuals pending resolution of their residency status and criteria for resolving disputed residency of individuals who (select all that apply):

- Are IV-E eligible
- Are in the state only for the purpose of attending school
- Are out of the state only for the purpose of attending school
- Retain addresses in both states
- Other type of individual

The state has a policy related to individuals in the state only to attend school.

Yes  No

Provide a description of the policy:

Medicaid eligibility is based upon the tax filing status of the individual. If the individual is claimed as dependent by an out-of-state tax filer, the individual is ineligible for medical assistance unless the individual provides additional evidence of residency.

Otherwise meet the criteria of resident, but who may be temporarily absent from the state.





## Medicaid Eligibility

The state has a definition of temporary absence, including treatment of individuals who attend school in another state.

Yes  No

Provide a description of the definition:

Medical assistance shall be provided to an individual temporarily absent from the state, which may include an individual attending school in another state and is claimed as a dependent by an in-state tax filer who:

- (1) Meets all conditions of eligibility for medical assistance as specified in the department rules;
- (2) Maintains Hawaii residency; and
- (3) Requires medical services outside the State under circumstances where services were emergent or when it would be impractical to return to the State for the necessary services.

### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**SUPERSEDING PAGES OF  
STATE PLAN MATERIAL**

**TRANSMITTAL NUMBER:**

13-0007-MM6

**STATE:**

Hawaii

**PAGE NUMBER OF THE PLAN SECTION OR  
ATTACHMENT:**

S89 Citizenship and Non-Citizenship  
Eligibility Template

**PAGE NUMBER OF THE SUPERSEDED PLAN  
SECTION OR ATTACHMENT (If Applicable):**

Attachment 2.6-A: Page 2, item (3),  
paragraphs (a) , (b), and (c),  
TN 09-003

Attachment 2.6-A: Page 3, item (3)(d),  
(e), and (f), TN 09-003



# Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

1902(a)(46)(B)  
8 U.S.C. 1611, 1612, 1613, and 1641  
1903(v)(2),(3) and (4)  
42 CFR 435.4  
42 CFR 435.406  
42 CFR 435.956

## Citizenship and Non-Citizen Eligibility

The state provides Medicaid to citizens and nationals of the United States and certain non-citizens consistent with requirements of 42

- CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

- The state provides Medicaid eligibility to otherwise eligible individuals:

- Who are citizens or nationals of the United States; and

Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity

- Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); and

- Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

- Yes    No

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

- Yes    No

The date benefits are furnished is:

- The date of application containing the declaration of citizenship or immigration status.  
 The date the reasonable opportunity notice is sent.  
 Other date, as described:

TN No: 13-0007-MM6

Approval Date: 09/13/2013

Effective Date: 10/01/2013

S89-1

Hawaii



# Medicaid Eligibility

The state provides Medicaid coverage to all Qualified Non-Citizens whose eligibility is not prohibited by section 403 of PRWORA (8 U.S.C. §1613).

Yes  No

The state elects the option to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

Yes  No

Pregnant women

Individuals under age 21:

Individuals under age 21

Individuals under age 20

Individuals under age 19

An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

An individual is considered to be lawfully present in the United States if he or she:

1. Is a qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

2. Is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

3. Is a non-citizen who has been paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

4. Is a non-citizen who belongs to one of the following classes:

Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

Granted employment authorization under 8 CFR 274a.12(c);

Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

Granted Deferred Action status;

Granted an administrative stay of removal under 8 CFR 241;

Beneficiary of approved visa petition who has a pending application for adjustment of status;

5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture who -

Has been granted employment authorization; or

Is under the age of 14 and has had an application pending for at least 180 days;



## Medicaid Eligibility

6. Has been granted withholding of removal under the Convention Against Torture;
7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);
8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or
9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b));
10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

Other

The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the SSA and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:

Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613;

Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

### PRA Disclosure Statement

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**SUPERSEDING PAGES OF  
STATE PLAN MATERIAL**

**TRANSMITTAL NUMBER:**

13-0007-MM1

**STATE:**

Hawaii

Pages or sections of pages being superseded by S25, S28, S30, S51, S52, S53, S54, S55 and S14 and related pages or sections of pages being deleted as obsolete

State Plan Section	Complete Pages Removed	Partial Pages Removed
Attachment 2.2-A	Page 1 Page 3 Page 3a Page 4 Page 4a Page 12 Page 13 Page 13a Page 14 Page 14a Page 21 Page 23 Page 23b	Page 2, A.2.b Page 2, A.2.c Page 2a, A.3 Page 9c, B.1 remove "Caretaker relatives" and "Pregnant women" Page 20, B.14 Page 23c, B.19 Page 23c, B.22 Page 25, C.4
Supplement 1 to Attachment 2.2-A	Page 1	
Attachment 2.6-A	Page 3b Page 11a Page 16 Page 19 Page 19a Page 19b Page 21	Page 1, A.2.a(i) and (iii) Page 6 related to AFDC recipients, pregnant women, infants, and children Page 7, 1.a(1) and (2) Page 12, 5.e(2) and (3) Page 18, 5.e Page 25, 11.a(3)
Supplement 1 to Attachment 2.6-A	Pages 1-4	
Supplement 2 to Attachment 2.6-A	Pages 1-5	

Supplement 5a to Attachment 2.6-A		Page 1, "Pregnant women and children - no limit on resources"
Supplement 8a to Attachment 2.6-A		Page 1, #1 Page 1, #2 delete citations for AFDC-related groups Page 2, delete citations for AFDC-related groups
Supplement 14 to Attachment 2.6-A	Page 1	
Supplement 15 to Attachment 2.6-A	Pages 1-3	



# Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and  
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way





# Medicaid Eligibility

Household size	Standard (\$)
1	493
2	653
3	795
4	938
5	1,083
6	1,232
7	1,391
8	1,508
9	1,623
10	1,739
11	1,857
12	1,974
13	2,091
14	2,208
15	2,325

Additional incremental amount

Yes  No

Increment amount \$

The dollar amounts increase automatically each year

Yes  No

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement



# Medicaid Eligibility

Standard varies in some other way

Household size	Standard (\$)
1	418
2	565
3	712
4	859
5	1,006
6	1,153
7	1,300
8	1,446
9	1,593
10	1,740
11	1,887
12	2,034
13	2,181
14	2,328
15	2,475

Additional incremental amount  
 Yes    No  
Increment amount \$

The dollar amounts increase automatically each year

Yes    No

The standard is as follows:

Statewide standard



# Medicaid Eligibility

- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes
- No

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes
- No

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes
- No



# Medicaid Eligibility

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes
- No

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes
- No

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes
- No



# Medicaid Eligibility

## PRA Disclosure Statement

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# Medicaid Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: 13 - 07 - 0000

Expiration date: 10/31/2014

## Presumptive Eligibility by Hospitals S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

Yes     No

The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

A qualified hospital is a hospital that:

Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of

its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance

with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

Yes     No

The eligibility groups or populations for which hospitals determine eligibility presumptively are:

Pregnant Women

Infants and Children under Age 19

Parents and Other Caretaker Relatives

Adult Group, if covered by the state

Individuals above 133% FPL under Age 65, if covered by the state

Individuals Eligible for Family Planning Services, if covered by the state

Former Foster Care Children

Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

Other Family/Adult groups:

Eligibility groups for individuals age 65 and over

Eligibility groups for individuals who are blind

Eligibility groups for individuals with disabilities

Other Medicaid state plan eligibility groups

Demonstration populations covered under section 1115



# Medicaid Eligibility

The state establishes standards for qualified hospitals making presumptive eligibility determinations.

Yes     No

Select one or both:

- The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Description of standards:

1. An 85% accuracy rate for correctly determined applications for HPE. This will be determined analyzing the HPE applications submitted by the hospital and evaluated for accuracy by EB staff;
2. 90% of individuals are offered help from hospital PE staff to complete the full Medicaid application;
3. 90% of hospital PE applicants will either submit a DHS 1100 application or an attestation sheets (completed by hospital staff for individuals who did not want to apply for regular Medicaid); and
4. 90% of hospital PE application packets shall be submitted timely (within 5 days from submission of HPE application) by the participating hospital to Med-QUEST Eligibility Branch.

- The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

- The presumptive period begins on the date the determination is made.

- The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

- Periods of presumptive eligibility are limited as follows:

- No more than one period within a calendar year.
- No more than one period within two calendar years.
- No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
- Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

Yes     No

- The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.
- The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

**An attachment is submitted.**



# Medicaid Eligibility

- The presumptive eligibility determination is based on the following factors:
  - The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)
  - Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.
  - State residency
  - Citizenship, status as a national, or satisfactory immigration status
- The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

**An attachment is submitted.**

## PRA Disclosure Statement

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V.20140415





## Application for Presumptive Eligibility for Medicaid

Use this form to find out quickly if you qualify for presumptive eligibility for Medicaid. Presumptive eligibility offers you and your family immediate access to health care while you apply for regular Medicaid or other health coverage.

To find out if you qualify for regular Medicaid or other health coverage, you must complete the Hawaii Application for Health Coverage & Help Paying Costs. While you wait to learn if you qualify for regular Medicaid or other health coverage, you can get your health services through presumptive eligibility for Medicaid.

You can also apply for regular Medicaid and other health coverage online at [mybenefit.hawaii.gov](http://mybenefit.hawaii.gov), via telephone, in person, or by mail.



### Who can qualify for presumptive eligibility for Medicaid?

You can qualify for presumptive eligibility for Medicaid if you meet all of these rules:

- Your income is below the applicable monthly limit.
- You are a U.S. citizen, U.S. national, or eligible non-citizen.
- You do not already have Medicaid.
- You have not had presumptive eligibility for Medicaid in the past 12 months.
- If you are pregnant, you have not had presumptive eligibility for Medicaid during this pregnancy.
- You are in one of the groups that qualifies for presumptive eligibility for Medicaid:
  - Children under 19 years of age
  - Parents and caretaker relatives
  - Pregnant women
  - Other adults age 19 – 64 years
  - People under age 26 who were in foster care



### How can I get help with this application?

Ask your hospital representative or call us toll free at 1-800-316-8005. If you need help in a language other than English, call toll free at 1-800-316-8005 and tell the customer services representative the language you need. We will get you help at no cost to you. TTY/TTD users call toll free at 1-800-603-1201.

<p>This is an important letter from the Department of Human Services. Please call the phone number located on the letter. When you call, you will be asked what language you speak and your call will be put on hold for an interpreter. You can also call 1-800-316-8005 for all DHS services.</p>	<p><b>English</b> </p>
<p>這是一封從人類服務部門發出的重要信件。請撥打信上的電話號碼。當你打電話時，你將會被詢問你講什麼語言，您的通話將被擱置直到接通翻譯服務。其他人類服務部門的服務，您可以致電到 1-800-316-8005。</p>	<p><b>Cantonese</b> </p>
<p>Ei taropwe mi auchchea seni ewe putain tumwunun aramas (Department of Human Services). Kose mwochen kokkori na nampan foon won na taropwe. Nupwen omw kokko, repwe eisnuk menni kkapas ke sine pwe repwe kkutta ngonuk emon choon chiaku. Ka pwan tongeni kokkori 1-800-316-8005 ren meinisin aninnis seni DHS.</p>	<p><b>Chuukese</b> </p>
<p>Ceci est une lettre importante du Department of Human Services (DHS). S'il vous plaît, faire un appel téléphonique au numéro de téléphone situé sur la lettre. Lorsque vous téléphonez, quelqu'un va vous demander quelle langue vous parlez, et votre appel sera mis en attente pour un interprète. Vous pouvez aussi téléphoner 1-800-316-8005 pour tous les services de DHS.</p>	<p><b>French</b> </p>
<p>Dies ist ein wichtiger Brief von der Abteilung Menschlicher Dienste (DHS). Bitte rufen Sie die Telefonnummer, die auf dem Brief gefunden wurde. Wenn Sie rufen, werden Sie gefragt werden, welche Sprache Sie sprechen, und Ihr Anruf wird auf Wartestellung für einen Dolmetscher geschaltet werden. Sie können 1-800-316-8005 für alle DHS Dienste auch rufen.</p>	<p><b>German</b> </p>
<p>He leka ko'iko'i keia mai ka 'Oihana Lawelawe Kanaka (Department of Human Services). E kelepona mai i ka helu kelepona ma luna o ka leka. Ke kelepona 'oe, e ninau 'ia ana 'oe he aha kau 'olelo 'oiwi a laila e kali 'oe a loa'a ke kanaka mahele 'olelo. Hiki pu ia 'oe ke kelepona i 1-800-316-8005 no na lawelawe a pau a ka 'Oihana Lawelawe Kanaka (DHS).</p>	<p><b>Hawaiian</b> </p>
<p>Daytoy ket importante nga surat nga naggapu iti Department of Human Services. Pangaasi nga tawagan yo iti numero iti telepono nga nakakabil iti daytoy nga surat. Nu umawag kayo, saludsuden da nu anya iti panagsasao yo ket urayen yo nga maiyallatiw iti tawag yo iti interpreter. Mabaln kayo nga umawayg iti 1-800-316-8005 para kadagiti amin nga serbisyo iti DHS.</p>	<p><b>Ilocano</b> </p>
<p>ハワイ州人道的奉仕局からの大切なお知らせです。この紙面に書かれている番号にお電話ください。電話をされた時に、貴方がどの言語を話されているかを聞かれます、通訳に接続されるまでしばらくお待ちください。DHSのどのサービスにも、この電話番号 1-800-316-8005 で対応いたします。</p>	<p><b>Japanese</b> </p>
<p>인간 서비스 부서에서 보내는 중요한 편지입니다. 이편지에 기재된 전화번호로 전화를 하세요. 당신이 전화를 할때 당신이 사용하는 언어를 물어것이고 그언어의 통역인에게 연결할것 입니다. 당신은 모든 인간 서비스 부서(디에이치에스)에 도움을 받기 위해서 1-800-316-8005 로 전화 할수 있습니다</p>	<p><b>Korean</b> </p>
<p>这是一封从人类服务部门发出的重要信件。请拨打信上的电话号码。当你打电话时，你将会被询问你讲什么语言，您的通話將被擱置直到接通翻譯服務。其他人類服務部門的服務，您可以致電到 1-800-316-8005。</p>	<p><b>Mandarin</b> </p>
<p>Juon in kojela im elap an aurok im ej itok jen ra eo an department of human services. Jouij im call e nomban in im ej bed ilo pepa in ak letta in. Ne koj call, renej kajitok ibbem kin kain kajin eo am im elikin am ba renej ba kwon kottar bwe ren lewoj juon am ri okok. Komaron call 1-800-316-8005 non aolepen ra ko kajojo ilo DHS services.</p>	<p><b>Marshallese</b> </p>
<p>O se fa'asilasilaga ta'ua lenei mai le Ofisa o le Human Services. Fa'amolemole, vala'au mai i le numera lea o lo'o i luga o lenei tusi. A e vala'au mai, o le a fesili atu po'o le a le gagana e te mo'omia, ona tu'u sa'o lea o lau telefoni i se tagata e mafai ona fesoasoani ia oe. E mafai fo'i ona e vala'au i le number 1-800-316-8005 mo nisi 'au'aunaga mai lenei Ofisa."</p>	<p><b>Samoan</b> </p>
<p>Ésta es una carta importante de la Sección de Servicios Humanos (DHS). Por favor llame el número de teléfono localizado en la carta. Cuando usted llame, usted se preguntará qué idioma usted habla y su llamada se pondrá en espera para un intérprete. Usted también puede llamar 1-800-316-8005 para todos los servicios de DHS.</p>	<p><b>Spanish</b> </p>
<p>Ito ay mahalaga na sulat na galling sa Department of Human Services. Mangyaring tawagan ang numero na nakalagay sa sulat na ito. Kung kayo ay tatawag, tatanungin kung ano ang iyong wika at hintayin ninyo hanggat may sumagot na tagasalin. Pwede ninyong tumawag sa 1-800-316-8005 para sa lahat ng serbisyo sa</p>	<p><b>Tagalog</b> </p>
<p>Ko e tohi mahu'inga eni mei he Potungaue Ngaue Ma'ae Kakai. Katakai 'o telefoni ki he fika 'oku ha 'i he tohi ni. 'E fehu'i atu pe ko e ha e fa'ahinga lea 'oku ke lea'aki 'i he taimi te ke ta mai ai pea taitokoe ke tali kae 'oua kuo ma'u ha toko taha fakatonu lea. Te ke lava 'o ta ki he ki he ngaahi tokoni kotoa 'a e DHS.</p>	<p><b>Tongan</b> </p>
<p>Đây là lá thư quan trọng từ các Bộ Phục Vụ Nhân Dân (DHS). Làm ơn gọi số điện thoại nằm trên lá thư. Khi bạn gọi, bạn sẽ được hỏi ngôn ngữ nào bạn nói và số điện thoại của bạn sẽ chờ người thông dịch. Đồng thời bạn cũng có thể gọi số 1-800-316-8005 cho các phục vụ DHS.</p>	<p><b>Vietnamese Việt Nam</b></p>
<p>Kini importante nga sulat gikan sa Department of Human Services (DHS). Palihug tawagi ang numero sa maong telepono nga nahimutang sa sulat. Sa imong pagtawag, ikaw pangutan-on kun unsa ang imong pinulongan ug ang imong tawag ilang ipahulat para sa usa ka taghubad sa pinulongan. Mahimo usab nga imong tawagan ang 1-800-316-8005 para sa tanang mga serbisyo sa DHS.</p>	<p><b>Visayan</b> </p>

# STEP 1 Tell us about yourself.

We need one adult in the family to be the contact person for your application.

1. First Name	Middle name	Last name	Suffix
2. Home address (Leave blank if you don't have one.)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. County
14. Phone number (      )		15. Other phone number (      )	
16. Do you want to get information about this application by email? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Email address: _____			
17. What is your preferred spoken language (if not English)?		18. What is your preferred written language (if not English)?	

# STEP 2 Tell us about your family.

List yourself and the members of your immediate family who live with you. Include your spouse, your children under the age of 19 years if they live with you and anyone you include on your tax return, even if they don't live with you.

Name <i>(first, middle, last)</i>	Date of birth (XX/XX/XXXX)	Relationship to you	Applying for presumptive eligibility for Medicaid? (Yes or No)	Already has Medicaid or other medical insurance? (Yes or No)	U.S. Citizen, U.S. National or eligible Non-citizen? (Yes or No)	Resident of Hawaii (Yes or No)	Social Security Number (SSN) (You don't have to provide this now, but it helps us determine eligibility for regular Medicaid faster)
(Same as above)		(Self)					

## STEP 3

### Other questions.

Answer these questions for yourself and your family members listed in Step 2. Your answers will make it easier to find out if you and any family member(s) qualify.

Is anyone pregnant who is applying for presumptive eligibility for Medicaid?  Yes  No

If yes, who? \_\_\_\_\_ How many babies does she expect? \_\_\_\_\_

Is anyone who is applying for presumptive eligibility for Medicaid receiving Medicare or Social Security Income (SSI)?  Yes  No

If yes, who? \_\_\_\_\_

Is anyone who is applying for presumptive eligibility for Medicaid a parent or caretaker relative?  Yes  No

*For example, a grandparent who is the main person taking care of a child.*

If yes, who? \_\_\_\_\_

Was anyone who is applying for presumptive eligibility for Medicaid in foster care at age 18?  Yes  No

If yes, who? \_\_\_\_\_

## STEP 4

### Tell us about your family's income.

Write the total income before taxes are taken for all family members listed in Step 2.

◆ **Job income:** *For example, wages, salaries, and self-employment income.*

Amount \$ \_\_\_\_\_ How often? (check one)  Weekly  Biweekly  Monthly  Yearly

◆ **Other income** *For example, unemployment checks, alimony, or disability payments from the Social Security Administration ("SSDI"). Do **not** include Supplemental Security Income ("SSI payments") or any child support you receive.*

Amount \$ \_\_\_\_\_ How often? (check one)  Weekly  Biweekly  Monthly  Yearly

## STEP 5

### Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all questions this form to the best of my knowledge. I know that I may be subject to penalties under state or federal law if I provide false or untrue information.
- I understand that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting [www.hhs.gov/ocr/office/file](http://www.hhs.gov/ocr/office/file).
- The person who filled out Step 1 should sign this application.

Signature	Date (mm/dd/yyyy)
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## STEP 6

### If you qualify for presumptive eligibility for Medicaid, what happens next?

- You will get a notice from the hospital saying you were approved.
- **You can start using your presumptive eligibility for Medicaid coverage right away** for Medicaid covered services such as doctor visits, hospital care, and some prescription drugs. You can go to any health care provider who accepts Medicaid starting the day you are approved. To start using your presumptive eligibility for Medicaid, use your approval notice from the hospital saying you are approved.
- **To see if you qualify for regular Medicaid or other health coverage**, the hospital will help you fill out the Hawaii Application for Health Coverage & Help Paying Costs, if you choose. You can also apply for regular Medicaid and other health coverage online at [mybenefit.hawaii.gov](http://mybenefit.hawaii.gov), via telephone, in person, or by mail.
- **Your presumptive eligibility will end on the date your application for Medicaid is either approved or denied.** If you are denied, you will be referred to the Connector for other affordable insurance programs.
- **If you do not fill out and submit the Hawaii Application for Health Coverage & Help Paying Costs** to see if you qualify for regular Medicaid or other health coverage, your presumptive eligibility for Medicaid coverage will end on the last day of the month after the month you are approved.

*For example, if you qualified for presumptive eligibility for Medicaid in January, it will end on the last day of February.*

## STEP 7

### If you do not qualify for presumptive eligibility for Medicaid, what happens next?

You will get a notice from the hospital saying you were not approved. You cannot appeal the hospital's decision. But you can still apply for regular Medicaid or other health coverage using the Hawaii Application for Health Coverage & Help Paying Costs.



# **Hospital Presumptive Eligibility in Hawaii**

# Overview

- What is Hospital Presumptive Eligibility (HPE)?
- How hospitals can participate in HPE
- Hospital staff eligible to make HPE determinations
- Who is eligible and what are the HPE benefits?
- How the HPE Process works
- Contact information



# ACA Coverage Changes

The Affordable Care Act (ACA) was signed into law in March 2010; it makes major changes to how people secure health coverage in the U.S. Coverage changes include:

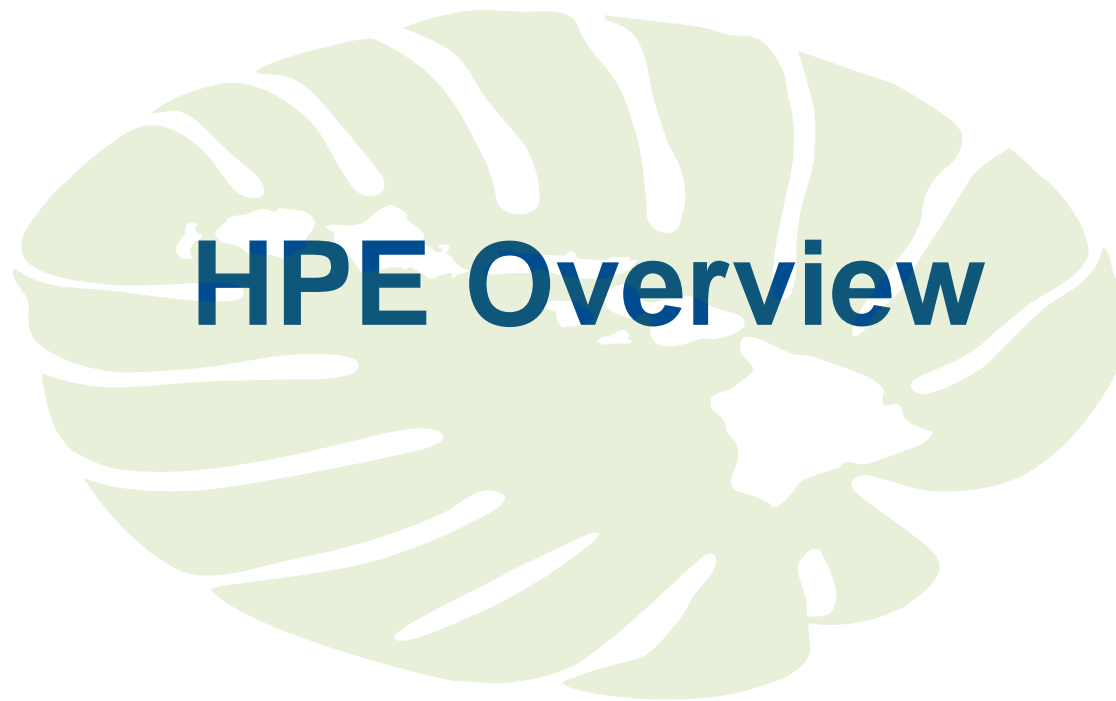
- Medicaid and CHIP expansion and improvements
- Health insurance marketplaces for individuals and small businesses
- Private insurance market reforms



# The New Vision for Medicaid and CHIP

- **Medicaid Coverage Expansion**
  - Covers adults 19-64 with incomes up to 133% FPL who are not eligible and enrolled in a mandatory group
- **Single, Streamlined Application**
  - Individuals can apply for Marketplace coverage and all insurance affordability programs (Medicaid, CHIP, premium tax credits) on one application
- **Simplified Eligibility and Enrollment Rules**
  - Modified Adjusted Gross Income (MAGI) is the new income methodology based on IRS-defined concepts of income and household to determine Medicaid and CHIP eligibility for children, pregnant women, parents and caretaker relatives, and adults 19-64
- **Modernized Eligibility Systems**
  - Increases use of automated rules engines to enable real-time eligibility determinations; individuals can apply for coverage online
- **Children's Coverage Improvements**
  - All children up to age 19 with family incomes up to 133% FPL are now Medicaid-eligible
- **Hospital Presumptive Eligibility**
  - Hospitals can now determine individuals to be presumptively eligible for Medicaid





# HPE Overview

# What Is Hospital Presumptive Eligibility (HPE)?

- As of January 1, 2014, hospitals can immediately determine Medicaid eligibility for certain individuals who are likely to be eligible.
- Eligibility under HPE is temporary but allows immediate access to coverage for eligible individuals.
- The policies and procedures for determining HPE may differ from the current policies and procedures for determining regular Medicaid assistance.



# Terms and Definitions

- **Application Signature:** The application must be signed by an adult household member (age 18 or over) or by an authorized representative.
- **Application Submission:** Applications may be submitted in person, by mail, or by fax.
- **Certain Individuals Needing Treatment for Breast or Cervical Cancer:** An individual who has been screened by an authorized CDC approved facility and requires treatment for breast or cervical cancer or a precancerous condition of the breast or cervix.
- **Dependent Child:** A child from birth to age 19
- **Eligibility Determination:** An approval or denial of eligibility.
- **Family Size Using Modified Adjusted Gross Income (MAGI) Methodology:** Means the number of persons counted as members of an individual's household. When determining the family size of individuals who have a pregnant woman in their household, the pregnant woman is counted just as herself.

# Terms and Definitions

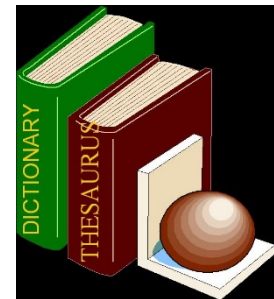
- **Former Foster Care Child:** An individual who is 18 to 26 years of age, not eligible for any other Medicaid coverage group, and was covered under Medicaid and in foster care when they turned age 18 or out of foster care.
- **Modified Adjusted Gross Income (MAGI):** The methodology used to determine financial eligibility.
- **Non-Applicant:** An individual who is not seeking an eligibility determination for himself or herself and is included in an applicant's or client's household to determine eligibility for such applicant or client.
- **Non-Filer:** Individuals who do not intend either to file taxes or to be claimed as a tax dependent.

# Terms and Definitions

- **Parent/Caretaker Relative:** A relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care, and who is one of the following:
  - ❖ The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece;
  - ❖ The spouse of such parent or relative including same sex marriage, even after the marriage is terminated by death or divorce; or
  - ❖ Another relative of the child based on blood, adoption, or marriage; the domestic partner of the parent or caretaker relative; or an adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

# Terms and Definitions

- **Pregnant Woman Hospital Presumptive Eligibility:** Medical coverage for an individual eligible in the Pregnant Women group is limited to prenatal services that are provided on an outpatient basis. For coverage of full Medicaid benefits, a pregnant woman must apply for regular Medicaid assistance.
- **Tax Dependent:** An individual for whom another individual claims a deduction for a personal exemption for a taxable year.
- **Tax Filer:** Individuals who intend to file a federal tax return for the coverage year and who do not intend to be claimed as a tax dependent by another taxpayer.



# How HPE Works to Get People Connected to Coverage and Care

- HPE improves individuals' access to Medicaid and necessary services by providing another channel to apply for medical coverage.
- Hospitals will be reimbursed for services provided during the PE period.
- HPE is not about short-term coverage; it provides individuals with an opportunity to get connected to longer-term coverage options.







# **How Hospitals Can Participate in HPE**

# How Hospitals Can Participate in HPE

- Hospital participation in HPE is optional, but States must provide a mechanism for a hospital to become qualified to offer the HPE program.
- To make HPE determinations, a hospital must:
  - ❖ Participate in the Medicaid program;
  - ❖ Notify the State of its election to make HPE determinations by contacting the Program Administrator;
  - ❖ Designated staff must complete HPE training modules;
  - ❖ Agree to make HPE determinations consistent with policies and procedures of the State by signing an attestation form;
  - ❖ Maintain performance standards set by State; and
  - ❖ Have a signed Memorandum of Agreement (MOA) with the Department on file.

# Hospital Staff Eligible to Make HPE Determinations

- Once a hospital is a qualified entity:
  - ❖ Any hospital employee who is properly trained and certified can make HPE determinations.
- Participating hospitals may not delegate HPE determinations to non-hospital staff:
  - ❖ Third party vendors or contractors may not make HPE determinations.
- Eligibility determinations will be based on MAGI non-filer rules:
  - ❖ The household's size will be determined by counting the individual plus their spouse and natural, adopted and step-children under age 19, or up to age 26 if a full time student, who are living together in the same household and who are not expected to be claimed by another tax-filer.



# How Will Hospitals Be Trained?

The Department will use a Medicaid training module consisting of:

- This powerpoint presentation, which provides an overview of the Hospital Presumptive Eligibility (HPE) program and application for full Medicaid requirements for participating hospital staff;
- HPE Workshop conducted by assigned DHS staff.

The Department will conduct additional training(s) to address hospital deficiencies after initial implementation of HPE :

- Department staff will monitor hospital ability to meet performance standards;
- Additional training will focus on areas that need improvement or additional guidance.



# Workshop and Training will include:

- Overview of HPE and regular Medicaid programs;
- Roles and responsibilities for the Hospital and Eligibility branch;
- Explanation of performance standards and requirements;
- Eligibility requirements for HPE, Children, Pregnant Women, Parent Caretaker Relatives, Adults, Former Foster Care Children and Certain Individuals Needing Treatment for Breast or Cervical Cancer \* coverage groups;
- How to complete the HPE application form, DHS 1100, and other applicable Medicaid forms;
- The HPE eligibility determination process using MAGI non-filer rules for household composition and income eligibility;
- How to prepare and submit the HPE packet to EB for processing;
- All bases of coordination between hospital and Med-QUEST required to process for HPE (assigned staff, contact numbers, etc).

\* Hospital must be designated as a CDC approved screening site for BCCEDP

# Process for Staff Training and Certification

- Hospitals must select staff for training and certification and provide list of names for Department;
- Hospitals must coordinate with Med-QUEST to arrange for training of staff;
- Selected staff must attend Department approved HPE/Medicaid Workshop and Training;
- Staff must complete Department approved workshop and training and become certified in order to make HPE determinations;
- Staff must sign agreement to comply with all MOA requirements for participation in the HPE program;
- Certified hospital staff will be able to determine eligibility and issue notice of approval for HPE coverage to eligible individuals.

# HPE Accuracy and Performance Standards

Hospitals shall be required to maintain the following performance standards to participate in the HPE program:


- 1) An 85% accuracy rate for correctly determined applications for HPE. This will be determined analyzing the HPE applications submitted by the hospital and evaluated for accuracy by EB staff;
- 2) 90% of individuals are offered help from hospital PE staff to complete the full Medicaid application;
- 3) 90% of hospital PE applicants will either submit a DHS 1100 application or an attestation sheets (completed by hospital staff for individuals who did not want to apply for regular Medicaid); and
- 4) 90% of hospital PE application packets shall be submitted timely (within 5 days from submission of HPE application) by the participating hospital to Med-QUEST Eligibility Branch.

# HPE Performance Standards

- The Department shall initially authorize a “Phase in “ period to help hospitals reach required performance standards without penalty for initial 6-12 months of HPE program implementation.
- The Department shall analyze initial performance standards and focus training on areas that are not meeting requirements. Hospitals not meeting HPE program requirements will complete additional training in deficient areas. If still unable to meet standards after additional training, hospital will be subject to disqualification from the HPE program.
- The Department has the authority to terminate hospital participation in the HPE program for failure to meet Department policies and established standards, including failure to participate in additional training when deficiencies are identified.







# **Who is Eligible to Enroll in Medicaid through HPE? What are the Benefits?**

# Populations Eligible for Medicaid via HPE Determinations

- Individuals who fall into one of the following MAGI groups may be determined for HPE:  
Children, Pregnant Women, Parents and Caretaker relatives, Adults, Former Foster Care Children and Certain Individuals Certain Individuals Needing Treatment for Breast or Cervical Cancer who are:
  - Not currently receiving Medicaid benefits and have not had a PE period in the last 12 months or for the same pregnancy (for a pregnant woman);
  - A Hawaii resident; and
  - A U.S. citizen or qualified non-citizen who meets Medicaid citizenship status requirements.



# Criteria for Determining HPE Eligibility

The current MAGI rules are used to determine the following:

- Household Size;
- Coverage Group; and
- Financial Eligibility.
- The Department will use non-filer MAGI rules when determining financial eligibility for the HPE program.



# HPE Income Eligibility Chart

## 2015 Standards of Assistance

HH Size	Parents or Caretaker Relatives		Adults/ Children 6-19		Children 1 < 6		Pregnant Women/ Child < 1		SCHIP Children < 19	
	100%	105%*	133%	138%*	139%	144%*	191%	196%*	308%	313%*
1	\$1,130	\$1,186	\$1,502	\$1,502	\$1,570	\$1,626	\$2,157	\$2,157	\$3,478	\$3,535
2	\$1,528	\$1,528	\$2,032	\$2,032	\$2,124	\$2,200	\$2,918	\$2,918	\$4,705	\$4,782
3	\$1,926	\$1,926	\$2,562	\$2,562	\$2,677	\$2,774	\$3,679	\$3,679	\$5,932	\$6,028
4	\$2,325	\$2,325	\$3,092	\$3,092	\$3,231	\$3,347	\$4,440	\$4,440	\$7,159	\$7,275
5	\$2,723	\$2,723	\$3,621	\$3,621	\$3,785	\$3,921	\$5,200	\$5,200	\$8,386	\$8,522
6	\$3,121	\$3,121	\$4,151	\$4,151	\$4,338	\$4,494	\$5,961	\$5,961	\$9,613	\$9,769
7	\$3,520	\$3,520	\$4,681	\$4,681	\$4,892	\$5,068	\$6,722	\$6,722	\$10,840	\$11,015
8	\$3,918	\$3,918	\$5,211	\$5,211	\$5,446	\$5,642	\$7,483	\$7,483	\$12,066	\$12,262
9	\$4,317	\$4,317	\$5,741	\$5,741	\$6,000	\$6,215	\$8,244	\$8,244	\$13,293	\$13,509
10	\$4,707	\$4,707	\$6,270	\$6,270	\$6,553	\$6,789	\$9,005	\$9,005	\$14,520	\$14,756
Each Add'l Person	\$399	\$419	\$530	\$550	\$554	\$574	\$761	\$781	\$1,227	\$1,247

\* Maximum allowable income with 5% disregard applied to the income standard as applicable.

**Note: 1) Former Foster Care Children have no income limit;**

**2) Financial eligibility for Certain Individuals Needing Treatment For Breast or Cervical Cancer is not subject to Medicaid income limits.**

# Countable Income Includes:

- Wages, salaries, tips, etc. ;
- Taxable interest;
- Alimony;
- Business income;
- Capital gains;
- Unemployment benefits;
- Rental real estate, royalties, partnerships, S corporations, etc. ;
- Other taxable income.

**\*ASSETS ARE NOT COUNTED FOR THE MAGI ELIGIBILITY GROUPS**

# Non-Tax Filer MAGI rules

Non-Tax filer MAGI rules will be used to determine financial eligibility for HPE applicants, regardless of their actual tax filing status. To determine household size, count the following household members:

- a. Applicant (and if living with the applicant):
  - Spouse
  - Child(ren)\* under age 19 years
- b. If applicant is under age 19 (and if living with the applicant):
  - Spouse
  - Child(ren)\* under age 19 years;
  - Parent(s)\*
  - Sibling(s)\* under age 19 years

\*Includes natural or biological, adopted, or step (parent/child/sibling).  
For sibling, includes half- sibling.

# Determination of Household size, Income and Coverage Group

- 1) Evan (age 29) is applying for coverage for himself, his pregnant wife, Keira (age 26), and their daughter, Lilly (age 3) who all live together. Evan states he earns \$1800 per month from his job. Keira does not work. Although Evan and Keira intend to file jointly, MAGI non-filer rules are applied to determine eligibility for HPE .
- 2) Evan and Keira have daughter Lily, so are first determined for eligibility under the Parent/Caretaker Group. If not eligible in this group, would be considered under another applicable coverage group (i.e. Adults).

Lilly is under age 6, therefore, she is determined for eligibility under the Childrens Group (Child 1<6).

# Determination of Household size, Income and Coverage Group (Cont'd)

3) Using the HPE Income Eligibility chart:

- Evan and Keira's income of \$1,800 < \$1,926 Parent/Caretaker Group standard for a household size of 3, therefore, they are eligible under this coverage group.
- Lilly's income of \$1,800 < \$2,677 Children Group standard for a household size of 3, therefore she is eligible under this group.

4) Tax household composition, size and coverage groups for Evan, Keira, & Lilly are shown below:

HH	Evan	Keira	Lilly	Family Size	Income	Coverage Group
Evan	X	X	X	3	\$1,800	Parent/Caretaker
Keira	X	X	X	3	\$1,800	Parent/Caretaker
Lilly	X	X	X	3	\$ 1,800	Children



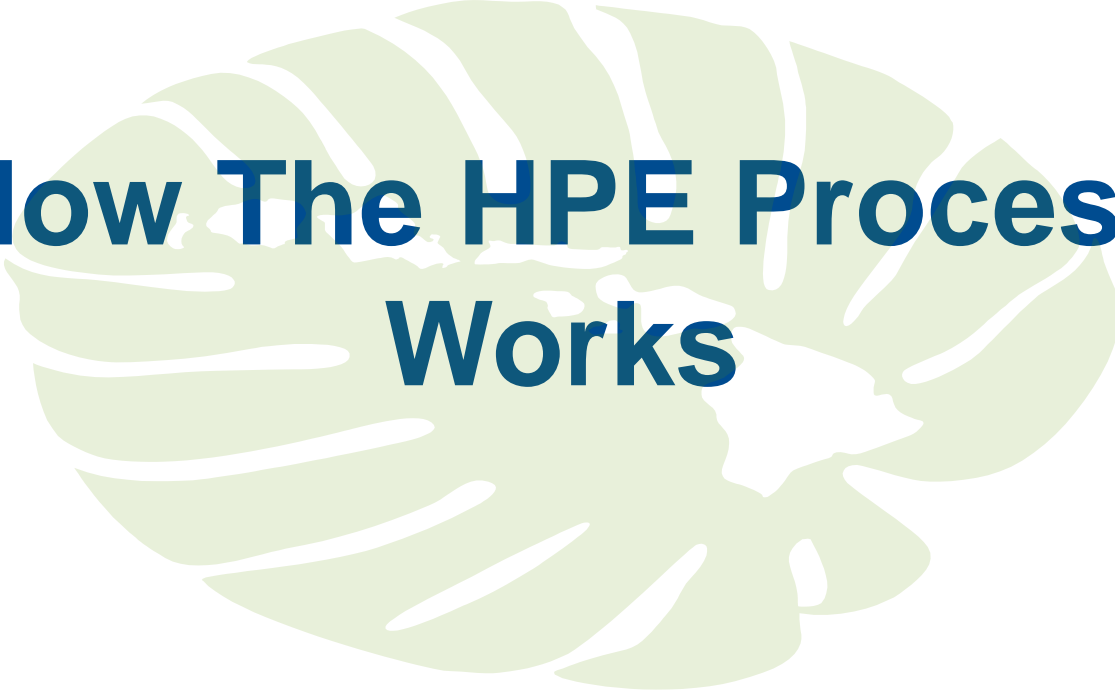
# What are the Benefits?

Individuals approved for presumptive eligibility receive the same Medicaid services as the group they are approved for under the Medicaid State Plan and 1115 Waiver as applicable. However, for individuals eligible in the Pregnant Women group, presumptive eligibility is limited to ambulatory prenatal care only.



# Duration of Eligibility under HPE

- The HPE period begins with, and includes, the day on which the hospital makes the HPE determination.
- The HPE period ends on:
  - ❖ The day on which the eligibility site makes the eligibility determination for full Medicaid; or
  - ❖ The last day of the month following the month in which the hospital makes the HPE determination if the individual did not apply for Medicaid.
- The HPE period is limited to one in a 12 month period and/or once per pregnancy for a pregnant woman.



# **How The HPE Process Works**

# Hospital PE Application

- The HPE application is a short application form for individuals to apply for hospital presumptive eligibility. It requests minimal information such as:
  - ❖ Contact information
  - ❖ Household members
  - ❖ Total income for the household
- For individuals with no previous Medicaid ID number, a temporary ID number will be created using the hospital's provider ID + the last 4 digits of the individual's SSN until a Medicaid ID number is generated by Med-QUEST staff;
- Hospital shall log all HPE applications and send monthly data to Med-QUEST for monitoring purposes.

# Verification of Eligibility Criteria

- Hospital Presumptive Eligibility determinations will be based on self-attestation of required information;
- Individual cannot be required to provide proof/documentation of any HPE eligibility criteria (e.g., can't require medical verification of pregnancy);
- Hospital/Department must accept self-attestation of income, citizenship/immigration status, State residency and household size.



# The HPE Determination Process

At the individual's initial visit, trained hospital staff shall:

- Check for current Medicaid eligibility by contacting the Enrollment Call Center for applicable information (Medicaid status, Medicaid ID number, Health plan);
- If already a Medicaid recipient, refer applicant to appropriate health plan for assistance, not eligible for HPE;
- If not a Medicaid recipient, determine if individual meets HPE eligibility requirements for appropriate coverage group;
- Self-attestation of previous or current Medicaid eligibility shall be accepted during non-business hours;
- If HPE requirements are met, help the individual complete the HPE application form for HPE. If determined ineligible for HPE, explain benefits of “regular” Medicaid and offer to help applicant complete the DHS 1100, “Application for Health Coverage & Help Paying Costs” form for submission to Med-QUEST if interested in applying;

# The HPE Determination Process (cont'd)

- Complete HPE eligibility determination and give applicant approval notice verifying applicant's HPE eligibility, coverage group and effective date of HPE coverage;
- Explain to applicant that the notice will serve as verification of eligibility for applicant;
- Offer assistance to applicant to apply for regular Medicaid by completing the DHS 1100 form.
- If applicant chooses not to apply for Medicaid, indicate this on the "Attestation sheet for DHS 1100" and sign in the field indicated on the bottom of the sheet.
- If applicant wants to apply for regular Medicaid, assist with application form and have HPE applicant sign and date the "Attestation sheet for DHS 1100"; and
- Submit with the HPE packet to the EB unit.

# Create HPE packet to send to Med-QUEST

Upon completion of the HPE determination, hospital staff shall:

- 1) Create HPE packet to fax to appropriate EB office consisting of:
  - Completed and signed HPE packet cover sheet;
  - Completed HPE application
  - HPE decision notice;
  - Completed DHS 1100 if applicable; and
  - Completed Attestation sheet for DHS 1100
- 2) Record HPE application on hospital HPE log and date information is faxed to EB;
- 3) Fax complete packet to the appropriate Med-QUEST office within 5 days for HPMMIS input and determination of regular Medicaid; and
- 4) Keep hard copies of HPE packets for future reference.



# Hospital PE Application



State of Hawaii  
Department of Human Services  
Med-QUEST Division

Please use this form to apply if you are a patient of the hospital, a patient's family member, or a community member.

## Application for Presumptive Eligibility for Medicaid

Use this form to find out quickly if you qualify for presumptive eligibility for Medicaid. Presumptive eligibility offers you and your family immediate access to health care while you apply for regular Medicaid or other health coverage.

To find out if you qualify for regular Medicaid or other health coverage, you must complete the Hawaii Application for Health Coverage & Help Paying Costs. While you wait to learn if you qualify for regular Medicaid or other health coverage, you can get your health services through presumptive eligibility for Medicaid.

You can also apply for regular Medicaid and other health coverage online at [mybenefit.hawaii.gov](http://mybenefit.hawaii.gov), via telephone, in person, or by mail.

### Who can qualify for presumptive eligibility for Medicaid?

You can qualify for presumptive eligibility for Medicaid if you meet all of these rules:

- Your income is below the monthly limit.
- You are a U.S. citizen, U.S. national, or eligible non-citizen.
- You do not already have Medicaid.
- You have not had presumptive eligibility for Medicaid in the past 12 months.
- If you are pregnant, you have not had presumptive eligibility for Medicaid during this pregnancy.
- You are in one of the groups that qualifies for presumptive eligibility for Medicaid:
  - Children under 19 years of age
  - Parents and caretaker relatives
  - Pregnant women
  - Other adults age 19 – 64 years
  - People under age 26 who were in foster care

### How can I get help with this application?

Ask your hospital representative or call us toll free at 1-800-316-8005. If you need help in a language other than English, call toll free at 1-800-316-8005 and tell the customer services representative the language you need. We will get you help at no cost to you. TTY/TTD users call toll free at 1-800-603-1201.

DHS 1000X

TN NO: 13-007-MM7

Approval Date November 18, 2015

<p>This is an important letter from the Department of Human Services. Please call the phone number located on the letter. When you call, you will be asked what language you speak and your call will be put on hold for an interpreter. You can also call 1-800-316-8005 for all DHS services.</p>	<p><b>English</b></p>
<p>這是一封從人類服務部門發出的重要信件。請撥打信上的電話號碼。當你打電話時，你將會被詢問你講什麼語言，你的通話將被轉接到通曉該語言服務。其他人類服務部門的服務，您可以致電到 1-800-316-8005。</p>	<p><b>Cantonese</b></p>
<p>El taropwe mi auchchea seni ewe putain tumwunun aramas (Department of Human Services). Kose mwochen kokkori na nampun foon won na taropwe. Nupwen omw kokko, repwe eisunik menni kkapas ke sine pwe repwe kkutta ngonuk emon choon chiaku. Ka pwan tongeni kokkori 1-800-316-8005 ren meisinin aninisin seni DHS.</p>	<p><b>Chukese</b></p>
<p>Ceci est une lettre importante du Department of Human Services (DHS). S'il vous plaît, faire un appel téléphonique au numéro de téléphone situé sur la lettre. Lorsque vous téléphonez, quelqu'un va vous demander quelle langue vous parlez, et votre appel sera mis en attente pour un interprète. Vous pouvez aussi téléphoner 1-800-316-8005 pour tous les services de DHS.</p>	<p><b>French</b></p>
<p>Dies ist ein wichtiger Brief von der Abteilung Menschlicher Dienste (DHS). Bitte rufen Sie die Telefonnummer, die auf dem Brief gefunden wurde. Wenn Sie rufen, werden Sie gefragt werden, welche Sprache Sie sprechen, und ihr Anruf wird auf Wartestellung für einen Dolmetscher geschaltet werden. Sie können 1-800-316-8005 für alle DHS Dienste auch rufen.</p>	<p><b>German</b></p>
<p>He leka ko'iko'i keia mai ka 'Oihana Lawelawe Kanaka (Department of Human Services). E kelepona mai i ka helu kelepona ma luna o ka leka. Ke kelepona 'oe, e ninau 'ia ana 'oe he aha kau 'olelo 'oiwi i laila e kali 'oe a loa' a ke kanaka mahele 'olelo. Hiki pu ia 'oe ke kelepona i 1-800-316-8005 no na lawelawe a pau a ka 'Oihana Lawelawe Kanaka (DHS).</p>	<p><b>Hawaiian</b></p>
<p>Daytoy ket importante nga surat nga nagpapa Department of Human Services. Pangaasi nga tawagan yo ni numero ni telepono nga nakakabil ni daytoy nga surat. Nu umawang kayo, saludsuden da nu anya ni panagasasao yo ket urayan yo nga mayalaltan ni tawag yo ni interpreter. Mabalin kayo nga umawang ni 1-800-316-8005 para kadagiti amin nga serbisyo ni DHS.</p>	<p><b>Ilocano</b></p>
<p>ハワイ州人道的福祉局からの大切なお知らせです。この紙面に書かれている番号にお電話ください。電話をされた時に、島方言などの言語を話されているかを聞かれます。通訳に接続されるまでしばらくお待ちください。DHS のこのサービスにも、この電話番号 1-800-316-8005 で対応いたします。</p>	<p><b>Japanese</b></p>
<p>인간 서비스 부서에서 보내는 중요한 편지입니다. 이 편지에 기재된 전화번호로 전화를 하시요. 당신이 전화를 할때 당신이 사용하는 언어를 물어것이고 그 언어의 통역인에게 연결할것입니다. 당신은 모든 인간 서비스 부서(디에이치에스)에 도움을 받기 위해서 1-800-316-8005 로 전화 할수 있습니다</p>	<p><b>Korean</b></p>
<p>這是一封從人類服務部門發出的重要信件。請撥打信上的電話號碼。當你打電話時，你將會被詢問你講什麼語言，你的通話將被轉接到通曉該語言服務。其他人類服務部門的服務，您可以致電到 1-800-316-8005。</p>	<p><b>Mandarin</b></p>
<p>Juon in kojela im elap an aurok im ej itok jen ra eo an department of human services. Jouj im cnej e nomba in im ej bed ilo pepa in ak letta in. Ne koj call, renej kajitok ibbem kin kain kajin eo am im elikin am ba renej ba kwon kottar bwe ren lewojuon am ri okok. Komaron call 1-800-316-8005 non aolepen ra ko kajojo ilo DHS services.</p>	<p><b>Marshallese</b></p>
<p>O se fa'asilasilaga ta'ua lenei mai le Ofisa o le Human Services. Fa'amolemole, vala'au mai i le numera lea o lo'o i luga o lenei tusi. A e vala'au mai, o le a fesili atu po'o le a le gagana e te mo'omia, ona tu'u sa'o lea o lau telefoni i se tagata e mafai ona fesoasoania oe. E mafai fo'i ona e vala'au i le number 1-800-316-8005 mo nisi 'au/anuaga mai lenei Ofisa."</p>	<p><b>Samoan</b></p>
<p>Ésta es una carta importante de la Sección de Servicios Humanos (DHS). Por favor llame el número de teléfono localizado en la carta. Cuando usted llama, usted se preguntará qué idioma usted habla y su llamada se pondrá en espera para un intérprete. Usted también puede llamar 1-800-316-8005 para todos los servicios de DHS.</p>	<p><b>Spanish</b></p>
<p>Ilo ay mahalaga na sulat na galing sa Department of Human Services. Mangyaring tawagan ang numero na nakalagay sa sulat na ito. Kung kayo ay tatawag, tatanungin kung ano ang iyong wika at hintayin ninyo hanggang may sumagot na tagasalin. Pwede ninyong tumawag sa 1-800-316-8005 para sa lahat ng serbisyo sa</p>	<p><b>Tagalog</b></p>
<p>Ko e tohi mahu'inga eni mei he Potungau Ngaue Ma'ae Kakai. Katak'i o telefoni ki he fika 'oku ha i le tohi ni. 'E fehu'i atu pe ko e ha e fa'ahinga lea 'oku ke lea'aki i he taimi te ke ta mai al pea nitokoe ke tali kae 'oua kuo ma'u ha toko taha fakatonu lea. Te ke lava 'o ta ki he ki he ngaahi tokoni kotoa 'a e DHS.</p>	<p><b>Tongan</b></p>
<p>Đây là lá thư quang trong từ các Bộ Phục Vụ Nhân Dân (DHS). Làm ơn gọi số điện thoại nằm trên lá thư. Khi bạn gọi, bạn sẽ được hỏi ngôn ngữ nào bạn nói và có điện thoại của bạn sẽ chờ người thông dịch. Đồng thời bạn cũng có thể gọi số 1-800-316-8005 cho các phục vụ DHS.</p>	<p><b>Vietnamese Việt Nam</b></p>
<p>Kini importante nga sulat gikan sa Department of Human Services (DHS). Palihuge tawagi ang numero sa maong telepono nga nahimutang sa sulat. Sa imong pagtawag, ikaw pangatun-on kun unsa ang imong pinulongan ug ang imong tawag ilang ipahulat para sa usa ka taghubad sa pinulongan. Mahimo usab nga imong tawagan ug ang 1-800-316-8005 para sa tanang mga serbisyo sa DHS.</p>	<p><b>Visayan</b></p>

DHS 1000X

Effective Date: January 1, 2014

# Hospital PE Application

## STEP 1 Tell us about yourself.

We need one adult in the family to be the contact person for your application. \*\*

1. First Name \*      -Middle name \*      -Last name \*      -Suffix \*

2. Home address (Leave blank if you don't have one.) \*      3. Apartment or suite number \*

4. City \*      5. State \*      6. ZIP code \*      7. County \*

8. Mailing address (if different from home address) \*      9. Apartment or suite number \*

10. City \*      11. State \*      12. ZIP code \*      13. County \*

14. Phone number \*      15. Other phone number \*  
( → ) \*      ( → ) \*

16. Do you want to get information about this application by email?  Yes  No \*  
Email address: \*

17. What is your preferred spoken language (if not English)? \*      18. What is your preferred written language (if not English)? \*

## STEP 2 Tell us about your family.

List yourself and the members of your immediate family who live with you. Include your spouse, your children under the age of 19 years if they live with you and anyone you include on your tax return, even if they don't live with you.

Name * (first, middle, last)	Date of birth (XXXXXXXXXX)	Relationship to you *	Applying for presumptive eligibility for Medicaid? (Yes or No) *	Already has Medicaid or other medical insurance? (Yes or No) *	U.S. Citizen, U.S. National, or eligible Non-citizen? (Yes or No) *	Resident of Hawaii? (Yes or No) *	Social Security Number (SSN) (You don't have to provide this now, but it helps us determine eligibility for regular Medicaid faster) * #
(Same as above) *		(Self) *					

Answer for family members who are applying. If a person is not applying, you do not have to answer these questions for that person.

Section Break (Next Page)

## STEP 3 Other questions.

Answer these questions for yourself and your family members listed in Step 2. Your answers will make it easier to find out if you and any family member(s) qualify.

Is anyone pregnant who is applying for presumptive eligibility for Medicaid?  Yes  No  
If yes, who? \_\_\_\_\_ How many babies does she expect? \_\_\_\_\_

Is anyone who is applying for presumptive eligibility for Medicaid receiving Medicare or Social Security Income (SSI)?  Yes  No  
If yes, who? \_\_\_\_\_

Is anyone who is applying for presumptive eligibility for Medicaid a parent or caretaker relative?  
For example, a grandparent who is the main person taking care of a child.  Yes  No  
If yes, who? \_\_\_\_\_

Was anyone who is applying for presumptive eligibility for Medicaid in foster care at age 18?  Yes  No  
If yes, who? \_\_\_\_\_

## STEP 4 Tell us about your family's income.

Write the total income before taxes are taken for all family members listed in Step 2.

• **Job income:** For example, wages, salaries, and self-employment income.  
Amount \$ \_\_\_\_\_ How often? (check one)  Weekly  Biweekly  Monthly  Yearly

• **Other income:** For example, unemployment checks, alimony, or disability payments from the Social Security Administration ("SSDI"). Do not include Supplemental Security Income ("SSI payments") or any child support you receive.  
Amount \$ \_\_\_\_\_ How often? (check one)  Weekly  Biweekly  Monthly  Yearly

DHS 1000X

# Hospital PE Application

## STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all questions this form to the best of my knowledge. I know that I may be subject to penalties under state or federal law if I provide false or untrue information.
- I understand that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting [www.hhs.gov/ocr/office/file](http://www.hhs.gov/ocr/office/file).
- The person who filled out Step 1 should sign this application.

Signature	Date (mm/dd/yyyy)

Section Break (Continuous)

## STEP 6 If you qualify for presumptive eligibility for Medicaid, what happens next?

- You will get a notice from the hospital saying you were approved.
- You can start using your presumptive eligibility for Medicaid coverage right away for Medicaid covered services such as doctor visits, hospital care, and some prescription drugs. You can go to any health care provider who accepts Medicaid starting the day you are approved. To start using your presumptive eligibility for Medicaid, use your approval notice from the hospital saying you are approved.
- To see if you qualify for regular Medicaid or other health coverage, the hospital will help you fill out the Hawaii Application for Health Coverage & Help Paying Costs, if you choose. You can also apply for regular Medicaid and other health coverage online at [mybenefit.hawaii.gov](http://mybenefit.hawaii.gov), via telephone, in person, or by mail.
- Your presumptive eligibility will end on the date your application for Medicaid is either approved or denied. If you are denied, you will be referred to the Connector for other affordable insurance programs.
- If you do not fill out and submit the Hawaii Application for Health Coverage & Help Paying Costs to see if you qualify for regular Medicaid or other health coverage, your presumptive eligibility for Medicaid coverage will end on the last day of the month after the month you are approved.  
*For example, if you qualified for presumptive eligibility for Medicaid in January, it will end on the last day of February.*

Section Break (Continuous)

## STEP 7 If you do not qualify for presumptive eligibility for Medicaid, what happens next?

- You will get a notice from the hospital saying you were not approved. You cannot appeal the hospital's decision. But you can still apply for regular Medicaid or other health coverage using the Hawaii Application for Health Coverage & Help Paying Costs.

# Sample Approval Letter

State of Hawaii – Dept. of Human Services  
Med-QUEST Division  
Street address  
Honolulu, HI 96813



Applicant name: Jane Doe

Thank you for your Hospital Presumptive Eligibility (HPE) application dated January 2, 2013. We have reviewed the information you provided on the application and have made the following eligibility determination:

Name	
DOB	MM/DD/YYYY
ID	XXXXXX
Application Status	Approved
Coverage group	HPE: Pregnant Women group
Effective Date	January 2, 2013
Termination Date	Date of approved or denied eligibility for regular Medicaid or February 28, 2013 if no DHS 1100 is completed and submitted
Household size	2
Countable income	\$1,800
Applicable Income Standard	\$2,137

*Additional information:*

Use this letter to as proof of eligibility for the approved household member listed above. If you completed the DHS 1100 "Application for Health Coverage & Help Paying Costs" with help from the hospital staff, it will be sent to the Med-QUEST office to determine your eligibility for regular Medicaid, even if your application for HPE assistance was denied.

Your HPE will end on the date your application for regular Medicaid is either approved or denied by the Med-QUEST office. If you are approved, you will receive regular Medicaid. If you are denied, you will be referred to the Connector for other affordable insurance programs. Med-QUEST will send you a notice of the eligibility determination for regular Medicaid separately.

If you did not complete the application for regular Medicaid, your HPE will end on the last day of the month after the month your HPE application was approved.

If you have questions or need more information contact 1-800-316-8005.

Authority: H.A.R. 17-1711.1-30, 17-1714.1-2

If you are a TTY user or need help in a language other than English, call the phone number located on the letter. We will get you help at no cost.

Page 1 of 1

# Sample Denial Letter

State of Hawaii – Dept. of Human Services  
Med-QUEST Division  
Street address  
Honolulu, HI 96813



Applicant name: Jane Doe

Thank you for your Hospital Presumptive Eligibility (HPE) application dated January 2, 2015. We have reviewed the information you provided on the application and have made the following eligibility determination:



Name	
DOB	MM/DD/YYYY
ID	XXXXXXXX
Application Status	Denied
Coverage group	HPE: Pregnant Women group
Effective Date	January 2, 2015
Denial Reason	Excess income
Household size	2
Countable income	\$5,800
Applicable Income Standard	\$2,137

Additional information:

If you completed the DHS 1100 "Application for Health Coverage & Help Paying Costs" with help from the hospital staff, it will be sent to the Med-QUEST office to determine your eligibility for regular Medicaid, even if your application for HPE assistance was denied.

If you are approved, you will receive regular Medicaid. If you are denied, you will be referred to the Connector for other affordable insurance programs. Med-QUEST will send you a notice of the eligibility determination for regular Medicaid separately.

If you have questions or need more information contact 1-800-316-8005.

Authority: H.A.R. 17-1711.1-30, 17-1714.1-2

If you are a TTY user or need help in a language other than English, call the phone number located on the letter. We will get you help at no cost.

Page 1 of 1

# Attestation Sheet for DHS 1100

## Attestation Sheet for DHS 1100

\_\_\_\_\_  
Name of Hospital

This purpose of this form is to ensure the above hospital is meeting Department requirements for the Hospital Presumptive Eligibility (HPE) program. Signing this form is optional. However, by signing this form, you help the Department to verify the hospital is in compliance with program requirements to continue participation in the HPE program. |

I certify that \_\_\_\_\_:  
Name of hospital staff member

\_\_\_\_\_ helped me complete the DHS 1100 Application for Health Coverage & Help Paying Costs form;

Or

\_\_\_\_\_ explained the purpose of the DHS 1100 Application for Health Coverage & Help Paying Costs form and offered to help applicant to fill out the form, but applicant chose not to complete it at this time.

\_\_\_\_\_  
Print name of HPE applicant

\_\_\_\_\_  
Signature of HPE applicant or Hospital staff member  
(if applicant chooses not to sign form)

\_\_\_\_\_  
Date

# Sample of Cover Letter



## HPE PACKET COVER SHEET

\_\_\_\_\_  
Name of Hospital

To: MQD/EB Unit \_\_\_\_\_  
FAX Number: \_\_\_\_\_

From: \_\_\_\_\_  
FAX Number: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

Date: \_\_\_\_\_

### REVIEW AND PROCESS FOR MEDICAID ELIGIBILITY:

- HPE Packet Cover Sheet
- HPE Application with Approval/Denial Notice
- DHS 1100 "Application for Health Coverage & Help Paying Costs" and/or
- DHS 1100 Attestation Sheet

\_\_\_\_\_  
Print name of hospital staff member

\_\_\_\_\_  
Signature of hospital staff member

\_\_\_\_\_  
Date

# DHS 1100 Application for Health Coverage & Help Paying Costs

State of Hawaii  
Department of Human Services  
Hawaii Health Connector

## Application for Health Coverage & Help Paying Costs



### Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)



### Who can use this application?

- Use this application to apply for you or anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.



### Apply faster online

- Apply faster online at [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov).
- If you want to purchase insurance without help, apply directly at [hawaiihealthconnector.com](http://hawaiihealthconnector.com)



### What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family



### Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. We'll keep all the information you provide private and secure, as required by law. To view the Privacy Act Statement, go to [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov).



### What happens next?

Send your complete, signed application to the address on page 7. If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1-2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov) or call 1-877-628-5076. Filling out this application doesn't mean you have to buy health coverage.



### Get help with this application

- Online: [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov)
- Phone: Call the Contact Center at 1-877-628-5076 for assistance with completing and submitting an application or getting information on the status of your application.
- In person: There may be counselors in your area who can help. Visit our website or call 1-877-628-5076 for more information.
- Medicaid: For specific questions on Medicaid/CHIP eligibility, call 1-888-764-7586.

This is an important letter from the Department of Human Services. Please call the phone number located on the letter. When you call, you will be asked what language you speak and your call will be put on hold for an interpreter. You can also call 1-888-764-7586 for all DHS services.



這是一封從人類服務部門發出的重要信件。請撥打信上的電話號碼。當你打電話時，你將會被詢問你講什麼語言。你的通話將被轉接到接聽翻譯服務。其他人類服務部門的服務，你可以致電到 1-888-764-7586。

Ei taropwe mi auchchea seni ewe putain tumwunun aramas (Department of Human Services) Kose mwochen kokkori na nampan foon won na taropwe. Nuwpen omw kokko, repwe eisunik menni kkapas ke sine pwe repwe kkutta ngonuk emon choon chiaku. Ka owan tongeni kokkori 1-888-764-7586 ren meinisin anionis seni DHS.

Ceci est une lettre importante du Department of Human Services (DHS). Si vous plaît, faire un appel téléphonique au numéro de téléphone situé sur la lettre. Lorsque vous téléphonez, quelqu'un va vous demander quelle langue vous parlez, et votre appel sera mis en attente pour un interprète. Vous pouvez aussi téléphoner 1-888-764-7586 pour tous les services de DHS.

Dies ist ein wichtiger Brief von der Abteilung Menschlicher Dienste (DHS). Bitte rufen Sie die Telefonnummer, die auf dem Brief gefunden wurde. Wenn Sie rufen, werden Sie gefragt werden, welche Sprache Sie sprechen, und Ihr Anruf wird auf Wartestellung für einen Dolmetscher geschaltet werden. Sie können 1-888-764-7586 für alle DHS Dienste auch rufen.

He leka ko'iko'i keia mai ka 'Oihana Lawelawe Kanaka (Department of Human Services). E kelenona mai i ka helu kelepona ma luna o ka leka. Ke kelepona 'oe, e nūnau 'ia ana 'oe he aha kau 'olelo 'a laila e kail 'oe a loa'a ke kanaka mabele 'olelo. Hiki pu 'ia 'oe ke kelepona i 1-888-764-7586 no na lawelawe a pui a ka 'Oihana Lawelawe Kanaka (DHS).

Daytoy ket importante nga surat nga nagpaayo iti Department of Human Services. Pangasa nga lawagan yo iti numero iti telepono nga nakakabit iti daytoy nga surat. Nu umawag kayo, saludsuden da nu anya iti panagasasao yo ket urayan yo nga mayayalaw, iti tawag yo iti interpreter. Mabaln kayo nga umawag yo iti 1-888-764-7586 para kadaqiti amin nga serbisyo iti DHS.

ハワイ州人道的サービス局からの大切なお知らせです。この紙面に書かれている番号にお電話ください。電話をされた時に、担当者との言語を話されているかを確認されます。通訳に接続されるまでしばらくお待ちください。DHSのどのサービスにも、この電話番号 1-888-764-7586 で対応いたします。

인간 서비스 부서에서 보내는 중요한 편지입니다. 이 편지에 기재된 전화번호로 전화해 주십시오. 당신이 전화를 할 때 당신이 사용하는 언어를 물어볼 것이고 그 언어의 통역인에게 연결할 것 입니다. 당신은 모든 인간 서비스 부서(디에이치에스)에 도움을 받기 위해서 1-888-764-7586로 전화 할 수 있습니다.

這是一封從人類服務部門發出的重要信件。請撥打信上的電話號碼。當你打電話時，你將會被詢問你講什麼語言。你的通話將被轉接到接聽翻譯服務。其他人類服務部門的服務，你可以致電到 1-888-764-7586。

Juon in koieia im elap an aurok im ei iok jien ra eo an department of human services. Jouim im call e nomba in im ei bed ilo pepa in ak letta in. Ne koj call, renej kajitok ibhem kin kain kajin eo, am im elikin am ba renej ba kwon kottar bwe ren lewoi juon am ni okok. Komaron call 1-888-764-7586 non aolepen ra ko kaiolo ilo DHS services.

O se fa'asilasilaga ta'ua lenei mai le Ofisa o le Human Services. Fa'amole mola, vala'au mai i le numera lea o lo'o i luga o lenei tusi. A e vala'au mai, o le a lesili atu po'o le a le gagana e le mo'omia, ona tu'u sa'o le o lau telefoni i se tagata e mafai ona fesoasoani ia oe. E mafai fo'i ona e vala'au i le number 1-888-764-7586 mo nisi o'au'au'auaga mai lenei Ofisa.

Ésta es una carta importante de la Sección de Servicios Humanos (DHS). Por favor llame el número de teléfono localizado en la carta. Cuando usted llama, usted se preguntará qué idioma usted habla y su llamada se pondrá en espera para un intérprete. Usted también puede llamar 1-888-764-7586 para todos los servicios de DHS.

Ilo ay mahalaga na sulat na galling sa Department of Human Services. Mangyaring lawagan ang numero na nakalagay sa sulat na ilo. Kung kayo ay tatawag, tatanungin kung ano ang iyo wika at hintayin ninyo hanggang may sumagot na tagasalin. Pwede ninyong tumawag sa 1-888-764-7586 para sa lahat ng serbisyo sa DHS.

Ko e tohi mahuinga eni mei he Polunagwe. Nanaue Ma'ae Kakai. Katakai 'o telefoni ki he fika 'oku ha' i he tohi ni. 'E fohi ni. 'E fohi ni atu pe ko e ha e fa'ahinga lea 'oku ke lea'aki i he taimi te ke ma ai pea taitokoke ke tali kae. 'oua kua mau ha toko tauha fakatonu lea. Te ke lava 'o ta ki he ki he ngaahi tokoni kotoa 'a e DHS.

Đây là lá thư quan trọng từ các Bộ Phục Vụ Nhân Dân (DHS). Làm ơn gọi số điện thoại trên lá thư. Khi bạn gọi, bạn sẽ được hỏi ngôn ngữ nào bạn nói và cứ điện thoại của bạn sẽ chờ người thông dịch. Đừng thời bạn cũng có thể gọi số 1-888-764-7586 cho các phục vụ DHS.

Kini importante nga sulat gikan sa Department of Human Services (DHS). Palihug lawagi ang numero sa maong telepono nga nahimutang sa sulat. Sa imong pagtawag, ikaw pangutan-on kun unsa ang imong pinulongan ug ang imong tawag ilang ipahulat para sa usa ka taghubad sa pinulongan. Mahimo usab nga imong tawagan ang 1-888-764-7586 para sa tanang mga serbisyo sa DHS.

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TTY/TDD users should call 1-855-858-8604.

Approval Date

November 18, 2015

Effective Date: January 1, 2014



# DHS 1100 Application for Health Coverage & Help Paying Costs

## STEP 1

### Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name	Middle name	Last name	Suffix
2. Home address (Leave blank if you don't have one.)		3. Apartment or suite number	
4. City	5. State	6. Zip code	7. County
8. Mailing address (if different from home address)		9. Apartment or suite number	
10. City	11. State	12. Zip code	13. County
14. Phone number ( ) -	15. Other phone number ( ) -		
16. Do you want to get information about this application by email? <input type="checkbox"/> Yes <input type="checkbox"/> No Email address: _____			
17. What is your preferred spoken language (if not English)?		18. What is your preferred written language (if not English)?	
19. How many family members live with you?		20. Is any family member you usually live with incarcerated (detained or jailed) or residing in the Hawaii State Hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list their name(s): _____	

## STEP 2

### Tell us about your family.

#### Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

#### DO include:

- Yourself
- Your spouse
- Your children under 19 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on our tax return, even if they don't live with you
- Anyone else under 19 who you take care of and lives with you

#### You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 19)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone get the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than two (2) people in your family, you'll need to make a copy of the pages, and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

📍 TN NO: 13-007-MM7

NEED HELP WITH YOUR APPLICATION? Visit [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov) or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-855-858-8604.

Approval Date November 18, 2015

## STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name	Middle name	Last name	Suffix	2. Relationship to you? SELF
3. Date of birth (mm/dd/yyyy)		4. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
5. Social Security Number (SSN)				
5. We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit <a href="http://socialsecurity.gov">socialsecurity.gov</a> . TTY users should call 1-800-325-0778.				
6. Do you plan to file a federal income tax return NEXT YEAR? (You can still apply for health insurance even if you don't file a federal income tax return.) <input type="checkbox"/> Yes. If yes, please answer questions a-c. <input type="checkbox"/> No. If no, skip to question c.				
a. Will you file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of spouse: _____				
b. Will you claim any dependents on your tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name(s) of dependents: _____				
c. Will you be claimed as a dependent on someone's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the name of the tax filer: _____ How are you related to the tax filer? _____				
7. Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many babies are expected during this pregnancy? _____ Expected Due Date _____				
8. Do you need health coverage? (Even if you have insurance, there might be a program with better coverage or lower costs.) <input type="checkbox"/> Yes. If yes, answer all the questions below. <input type="checkbox"/> No. If no, SKIP to the income questions on page 3. Leave the rest of this page blank.				
9. Do you have a disability that will last more than twelve (12) months? <input type="checkbox"/> Yes <input type="checkbox"/> No a. Do you currently receive long term care nursing services? <input type="checkbox"/> Yes, in a nursing facility <input type="checkbox"/> Yes, in my home in the community <input type="checkbox"/> No b. Have you received long term care nursing services in the last three (3) months? <input type="checkbox"/> Yes. If yes, what date(s)? _____ <input type="checkbox"/> No c. Do you think you need long term care nursing services now? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Do you receive Supplemental Security Income (SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
10. Did you receive any medical services in the past ten (10) calendar days immediately prior to the date of this application? <input type="checkbox"/> Yes. If yes, what date(s)? _____ <input type="checkbox"/> No				
11. Are you a U.S. citizen or U.S. national? <input type="checkbox"/> Yes. If yes, skip to Question 13. <input type="checkbox"/> No If you aren't a U.S. citizen or U.S. national, please provide the information below. a. Immigration document type _____ b. Document ID number _____ c. When did you enter the U.S.? _____ d. Are you a citizen of the Federated State of Micronesia, the Republic of the Marshall Islands, and Palau. <input type="checkbox"/> Yes <input type="checkbox"/> No e. Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No				
13. Are you the primary or one of the primary person(s) taking care of a child under age 19 years that lives with you? <input type="checkbox"/> Yes <input type="checkbox"/> No				
14. Were you in foster care at age 18 or older in Hawaii? <input type="checkbox"/> Yes <input type="checkbox"/> No				
15. Are you a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No				
16. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.) <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other _____				
17. Race (OPTIONAL—check all that apply.) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Asian Indian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Japanese <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Chinese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Korean <input type="checkbox"/> Samoan <input type="checkbox"/> Other _____				

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# DHS 1100 Application for Health Coverage & Help Paying Costs

## STEP 2: PERSON 1 (Continue with yourself)

### CURRENT Job & Income Information

- Employed**  
If you're currently employed, tell us about your income. Start with question 18.
- Self-employed**  
Skip to question 27.
- Not employed**  
Skip to question 28.

#### CURRENT JOB 1:

18. Employer name and address \_\_\_\_\_ 19. Employer phone number ( ) - \_\_\_\_\_

20. Wages/tips (before taxes) \$ \_\_\_\_\_  
 Hourly  Weekly  Every 2 weeks  Twice a month  Monthly

21. Average hours worked each WEEK \_\_\_\_\_

#### CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address \_\_\_\_\_ 23. Employer phone number ( ) - \_\_\_\_\_

24. Wages/tips (before taxes) \$ \_\_\_\_\_  
 Hourly  Weekly  Every 2 weeks  Twice a month  Monthly

25. Average hours worked each WEEK \_\_\_\_\_

26. In the past year, did you:  Change jobs  Stop working  Start working fewer hours  None of these

27. If self-employed, answer the following questions:

a. Type of work \_\_\_\_\_

b. How much net income (profit business expenses are paid) will you get from this self-employment this month? \$ \_\_\_\_\_

#### 28. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support or veteran's payment.

<input type="checkbox"/> Unemployment \$ _____ How often? _____	<input type="checkbox"/> Net farming/fishing \$ _____ How often? _____
<input type="checkbox"/> Pensions \$ _____ How often? _____	<input type="checkbox"/> Net rental/royalty \$ _____ How often? _____
<input type="checkbox"/> Social Security \$ _____ How often? _____	<input type="checkbox"/> Other income \$ _____ How often? _____
<input type="checkbox"/> Retirement accounts \$ _____ How often? _____	Type: _____
<input type="checkbox"/> Alimony received \$ _____ How often? _____	

#### 29. DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

<input type="checkbox"/> Alimony paid \$ _____ How often? _____	<input type="checkbox"/> Other deductions \$ _____ How often? _____
<input type="checkbox"/> Student loan interest \$ _____ How often? _____	Type: _____

30. **NET YEARLY INCOME:** Complete if your net income changes a lot from month to month. If you don't expect changes to your monthly income, skip to the next person.

Your total income this year \$ \_\_\_\_\_ Your total income next year (if you think it will be different) \$ \_\_\_\_\_

**THANKS! This is all we need to know about you.**

If there is 2 or more people to include, please make a copy of STEP 2: PERSON 2 (Pages 4 and 5) and Complete

TN NO: 13-007-MM7

Approval Date

November 18, 2015

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## STEP 2: PERSON 2

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name \_\_\_\_\_ Middle name \_\_\_\_\_ Last name \_\_\_\_\_ Suffix \_\_\_\_\_ 2. Relationship to PERSON 1? \_\_\_\_\_

3. Date of birth (mm/dd/yyyy) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ 4. Gender  Male  Female

5. Social Security Number (SSN) \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

**We need this if you want health coverage and have an SSN.**

6. Does PERSON 2 live at the same address as you?  Yes  No  
If no, list address: \_\_\_\_\_

7. Does PERSON 2 plan to file a federal income tax return NEXT YEAR? (You can still apply for health insurance even if you don't file a federal income tax return.)

**Yes.** If yes, please answer questions a-c.  **No.** If no, skip to question c.

a. Will PERSON 2 file jointly with a spouse?  Yes  No  
If yes, name of spouse: \_\_\_\_\_

b. Will PERSON 2 claim any dependents on his/her tax return?  Yes  No  
If yes, list name(s) of dependents: \_\_\_\_\_

c. Will PERSON 2 be claimed as a dependent on someone's tax return?  Yes  No  
If yes, please list the name of the tax filer: \_\_\_\_\_  
How is PERSON 2 related to the tax filer? \_\_\_\_\_

8. Is PERSON 2 pregnant?  Yes  No If yes, how many babies are expected during this pregnancy? \_\_\_\_\_ Expected Due Date \_\_\_\_\_

9. Does PERSON 2 need health coverage? (Even if they have insurance, there might be a program with better coverage or lower costs.)

**Yes.** If yes, answer all the questions below.  **No.** If no, SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 2 have a disability that will last more than twelve (12) months?  Yes  No

a. Does PERSON 2 currently receive long term care nursing services?  Yes, in a nursing facility  Yes, in my home in the community  No

b. Has PERSON 2 received long term care nursing services in the last three (3) months?  Yes. If yes, what date(s)? \_\_\_\_\_  No

c. Does PERSON 2 need long term care nursing services now?  Yes  No

d. Does PERSON 2 receive Supplemental Security Income (SSI)?  Yes  No

11. Did PERSON 2 receive any medical services in the past ten (10) calendar days immediately prior to the date of this application?  Yes. If yes, what date(s)? \_\_\_\_\_  No

12. Is PERSON 2 a U.S. citizen or U.S. national?  Yes. If yes, skip to Question 14.  No

13. If PERSON 2 isn't a U.S. citizen or U.S. national, please provide the information below.

a. Immigration document type \_\_\_\_\_

b. Document ID number \_\_\_\_\_

c. When did PERSON 2 enter the U.S.? \_\_\_\_\_

d. Is PERSON 2 a citizen of the Federated State of Micronesia, the Republic of the Marshall Islands or Palau?  Yes  No

e. Is PERSON 2, or their spouse or parent, a veteran or an active-duty member of the U.S. military?  Yes  No

14. Is PERSON 2 the primary or one of the primary person(s) taking care of a child under age 19 years that lives with you?  Yes  No

15. Was PERSON 2 in foster care at age 18 or older in Hawaii?  Yes  No

16. Is PERSON 2 a full-time student?  Yes  No

17. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican  Mexican American  Chicano/a  Puerto Rican  Cuban  Other \_\_\_\_\_

18. Race (OPTIONAL—check all that apply.)

<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Other Pacific Islander
<input type="checkbox"/> Chinese	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Korean	<input type="checkbox"/> Samoan	<input type="checkbox"/> Other _____

Now, tell us about any income from PERSON 2 on the back.

Effective Date: January 1, 2014

NEED HELP WITH YOUR APPLICATION? Visit [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov) or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-855-858-8604.

# DHS 1100 Application for Health Coverage & Help Paying Costs

## STEP 2: PERSON 2

### CURRENT Job & Income Information

- Employed**  
 If you're currently employed, tell us about your income. Start with question 19.
- Self-employed**  
 Skip to question 28.
- Not employed**  
 Skip to question 29.

#### CURRENT JOB 1:

19. Employer name and address \_\_\_\_\_ 20. Employer phone number ( ) - \_\_\_\_\_

21. Wages/tips (before taxes)  Hourly  Weekly  Every 2 weeks  Twice a month  Monthly  
 \$ \_\_\_\_\_

22. Average hours worked each WEEK \_\_\_\_\_

#### CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

23. Employer name and address \_\_\_\_\_ 24. Employer phone number ( ) - \_\_\_\_\_

25. Wages/tips (before taxes)  Hourly  Weekly  Every 2 weeks  Twice a month  Monthly  
 \$ \_\_\_\_\_

26. Average hours worked each WEEK \_\_\_\_\_

27. In the past year, did PERSON 2:  Change jobs  Stop working  Start working fewer hours  None of these

#### 28. If self-employed, answer the following questions:

a. Type of work \_\_\_\_\_

b. How much net income (profit once business expenses are paid) will you get from this self-employment this month?  
 \$ \_\_\_\_\_

#### 29. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support or veteran's payment.

- |  |  |
|--|--|
| <input type="checkbox"/> Unemployment \$ _____ How often? _____        | <input type="checkbox"/> Net farming/fishing \$ _____ How often? _____ |
| <input type="checkbox"/> Pensions \$ _____ How often? _____            | <input type="checkbox"/> Net rental/royalty \$ _____ How often? _____  |
| <input type="checkbox"/> Social Security \$ _____ How often? _____     | <input type="checkbox"/> Other income \$ _____ How often? _____        |
| <input type="checkbox"/> Retirement accounts \$ _____ How often? _____ | Type: _____  |
| <input type="checkbox"/> Alimony received \$ _____ How often? _____    |  |

#### 30. DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 28b).

- |  |   |
|--|---|
| <input type="checkbox"/> Alimony paid \$ _____ How often? _____          | <input type="checkbox"/> Other deductions \$ _____ How often? _____ |
| <input type="checkbox"/> Student loan interest \$ _____ How often? _____ | Type: _____   |

#### 31. NET YEARLY INCOME: Complete if PERSON 2 net income changes a lot from month to month.

If you don't expect changes to PERSON 2 monthly income, skip to the next section. ➔

PERSON 2's total income this year \$ \_\_\_\_\_ PERSON 2's total income next year (if you think it will be different) \$ \_\_\_\_\_

**THANKS! This is all we need to know about PERSON 2.**

If there are no more people to include, skip to next page. ➔

TN NO: 13-007-MM7

Approval Date November 18, 2015

Effective Date: January 1, 2014

NEED HELP WITH YOUR APPLICATION? Visit [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov) or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-855-858-8604.

## STEP 3

### American Indian or Alaska Native (AI/AN) family member(s)

#### 1. Are you or is anyone in your family American Indian or Alaska Native.

- Yes. If yes, go to Appendix B.  
 No. If No, skip Step 4.

## STEP 4

### Your Family's Health Coverage

Answer these questions for anyone who need health coverage.

#### 1. Does anyone have health coverage or health insurance other than Medicaid?

- Yes. If yes, check the type of coverage and write the person(s) name(s) on the line provided and additional information as appropriate.

Employer insurance \_\_\_\_\_

Name of health insurance: \_\_\_\_\_

Policy number: \_\_\_\_\_

Is this COBRA coverage?  Yes  No

Is this a retiree health plan?  Yes  No

Medicare \_\_\_\_\_

TRICARE \_\_\_\_\_

(Don't check if you have direct care or Line of Duty)

VA health care programs \_\_\_\_\_

Peace Corp \_\_\_\_\_

Other \_\_\_\_\_

Name of health insurance: \_\_\_\_\_

Policy number: \_\_\_\_\_

Is this a limited-benefit plan (like a school accident policy)?  Yes  No

No

#### 2. Is anyone listed on this application offered health coverage from a job?

(Check YES even if the coverage is from someone else's job, such as a parent or spouse.)

- Yes. If yes, you'll need to complete and include Appendix A. Is this a state employee benefit plan?  Yes  No

No. If no, continue to Step 5.

#### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average (insert Time (hours or minutes)) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestion for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

NEED HELP WITH YOUR APPLICATION? Visit [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov) or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-855-858-8604.

# DHS 1100 Application for Health Coverage & Help Paying Costs

**!!!SIGNATURE REQUIRED BELOW!!!**

## STEP 5 Read and sign this application

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under state or federal law if I provide false and/or untrue information.
- I understand I must tell the Department of Human Services or the Hawaii Health Connector if anything changes (and is different than) what I wrote on this application. I can visit [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov) or call 1877-628-5076 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I understand that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation gender identity, or disability. I can file a complaint of discrimination by visiting [www.hhs.gov/ocr/office/file](http://www.hhs.gov/ocr/office/file).
- I understand the Department of Human Services and the Hawaii Health Connector will obtain information to verify eligibility with electronic databases, to include but not limited to, the Internal Revenue Services (IRS), Social Security Administration (SSA), Department of Homeland Security (DHS) or a consumer reporting agency. If the information doesn't match, we may ask to you send us proof.

### Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Hawaii Health Connector to use income data, including information from tax returns. The Hawaii Health Connector will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

- 5 years (the maximum number of years allowed), or for a shorter number of years:  
 4 years  3 years  2 years  1 years  **Don't** use information from tax returns to renew my coverage.

### If anyone on this application is eligible for Medicaid.

- I am assigning the Department of Human Services, my rights to payments for medical care from any third party, which may include but not limited to, other health insurance or legal settlement. I am also assigning the Department of Human Services, my rights to pursue and get medical support from a spouse or parent. I will cooperate in obtaining third party payments.
- Does any child on this application have a parent living outside of the home?  Yes  No. If yes, I understand I will be asked to cooperate with the Department of Human Services and the agency that collects medical support form an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.
- I agree to cooperate with the Department of Human Services, Federal Quality Control reviewers or auditors if my case is selected for a review.

### My right to appeal

If I think the Department of Human Services or the Hawaii Health Connector has made a mistake. I can appeal its decision. To appeal means to tell someone at the Department of Human Services or the Hawaii Health Connector that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting someone at 1-877-628-5076. I know that I can be represented in the process by someone other than myself. My eligibility and other information will be explained to me.

**Sign this application.** The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here with your name, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)
-----------	-------------------

## STEP 6 Mail your signed application to:

- |  |   |  |  |
|--|---|--|--|
| <b>MQD/EB</b><br><b>Oahu Section</b><br>P.O. Box 3490<br>Honolulu, HI 96811-3490   | <b>MQD/EB</b><br><b>Kapolei Unit</b><br>P.O. Box 29920<br>Honolulu, HI 96820-2320                                   | <b>MQD/EB</b><br><b>East Hawaii Section</b><br>1404 Kilauea Avenue<br>Hilo, HI 96720 | <b>MQD/EB</b><br><b>West Hawaii Section</b><br>Lanikai Professional Center<br>75-5591 Palani Road, Suite 3004<br>Kailua-Kona HI 96740-3633 |
| <b>MQD/EB</b><br><b>Lanai Unit</b><br>P.O. Box 631374<br>Lanai City, HI 96793-0737 | <b>MQD/EB</b><br><b>Maui Section</b><br>Milliard Plaza<br>210 Ima Kala Street, Suite 101<br>Honolulu, HI 96820-2320 | <b>MQD/EB</b><br><b>Molokai Unit</b><br>P.O. Box 1619<br>Kaunakakai, HI 96748-1619   | <b>MQD/EB</b><br><b>Kauai Section</b><br>4473 Pahae Street, Suite A<br>Lihue, HI 96766   |

If you want to register to vote you can complete the attached voter registration form or download a form from [hawaii.gov/elections](http://hawaii.gov/elections).

**TN NO: 13-007-MM7**

**Approval Date November 18, 2015**

**Effective Date: January 1, 2014**

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## APPENDIX A

### Health Coverage from Jobs

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

### EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Employee Social Security Number
--	------------------------------------

### EMPLOYER Information

Ask the employer for this section.

3. Employer name	4. Employer Identification Number (EIN)	
5. Employer address (notice will be sent to this address)	6. Employer phone number ( ) -	
7. City	8. State	9. Zip Code
10. Who can we contact about employee health at this job?		
11. Phone number (if different from above) ( ) -	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next three (3) months?

Yes (continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? \_\_\_\_\_

List the names of anyone else who is eligible for coverage from this job. mm/dd/yyyy

Name:	Name:	Name:
-------	-------	-------

No (STOP and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard\*?

Yes  No

15. For the lowest-cost plan that meets the minimum value standard\* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much will the employee have to pay in premiums for this plan? \$ \_\_\_\_\_  
 b. How often?  Weekly  Every 2 weeks  Twice a month  Once a month  Quarterly  Yearly

16. What change will the employer make for the new year (if known)?

Employer won't offer health coverage.

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.\* (Premium should reflect the discount for wellness programs. See question 15)

a. How much will the employee have to pay in premiums for that plan? \$ \_\_\_\_\_  
 b. How often?  Weekly  Every 2 weeks  Twice a month  Once a month  Quarterly  Yearly

Date of change (mm/dd/yyyy): \_\_\_\_\_

\*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit cost covered by the plan is no less than 60 percent of such costs (section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

**NEED HELP WITH YOUR APPLICATION?** Visit [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov) or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-855-858-8604.

# DHS 1100 Application for Health Coverage & Help Paving Costs

## EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

### EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Social Security Number
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

### EMPLOYER Information

Ask the employer for this section.

3. Employer name		4. Employer Identification Number (EIN)	
5. Employer address (notice will be sent to this address)		6. Employer phone number ( ) -	
7. City	8. State	9. Zip Code	
10. Who can we contact about employee health at this job?			
11. Phone number (if different from above) ( ) -		12. Email address	

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next three (3) months?

Yes (continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? \_\_\_\_\_ mm/dd/yyyy (Continue)

No (STOP and return this form to employee)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

Yes Which people?  Spouse  Dependent(s)

No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard\*?

Yes (Go to question 15)  No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard\* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ \_\_\_\_\_

b. How often?  Weekly  Every 2 weeks  Twice a month  Once a month  Quarterly  Yearly

If the plan year will end soon and you know the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

Employer won't offer health coverage.

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.\* (Premium should reflect the discount for wellness programs. See question 15)

a. How much will the employee have to pay in premiums for that plan? \$ \_\_\_\_\_

b. How often?  Weekly  Every 2 weeks  Twice a month  Once a month  Quarterly  Yearly

Date of change (mm/dd/yyyy): \_\_\_\_\_

\*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit cost covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(i) of the Internal Revenue Code of 1996)

**NEED HELP WITH YOUR APPLICATION?** Visit [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov) or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-855-858-3604.

APPENDIX A: 13-007-MM7

DHS 1100 (REV. 10/14)

Approval Date: \_\_\_\_\_

Appendix Page 3 of 4

## APPENDIX B

### American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s). American Indians and Alaska Natives can get services from the Indian Health Services, tribal health program, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1		AI/AN PERSON 2	
1. Name (First name, Middle name, Last name)	First	Middle	First	Middle
	Last		Last	
2. Member of a federally recognized tribe?	<input type="checkbox"/> Yes if yes, tribe name is: _____		<input type="checkbox"/> Yes if yes, tribe name is: _____	
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	<input type="checkbox"/> No		<input type="checkbox"/> No	
	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:	<ul style="list-style-type: none"> <li>Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties.</li> <li>Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).</li> <li>Money from selling things that have cultural significance.</li> </ul>		<ul style="list-style-type: none"> <li>Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties.</li> <li>Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).</li> <li>Money from selling things that have cultural significance.</li> </ul>	
	\$ _____ How often? _____		\$ _____ How often? _____	

**NEED HELP WITH YOUR APPLICATION?** Visit [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov) or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-855-858-3604.

APPENDIX B: 13-007-MM7

DHS 1100 (REV. 10/14)

Approval Date: November 18, 2015

Effective Date: January 1, 2014

Appendix Page 3 of 4

# DHS 1100 Application for Health Coverage & Help Paying Costs

## APPENDIX C

### Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, call 1-877-628-5076. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)			
2. Address		3. Apartment or suite number	
4. City	5. State	6. Zip code	
7. Phone number ( ) -			
8. Organization name		9. ID number (if applicable)	
By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.			
10. Your signature		11. Date (mm/dd/yyyy)	

### Authorized Representative

As the designated Authorized Representative, I agree to maintain the confidentiality of any information provided to me by the Department or its designee and I can be released as the Authorized Representative by signing below.

Signature of Authorized Representative		Telephone	Date
Street Address		City	State Zip Code
As applicable, I _____, am a provider or staff member or volunteer of an organization: _____		PRINT Name of Individual PRINT Name of Provider/Organization	

I understand and agree, as a condition of serving as the Authorized Representative, will adhere to the regulations relating to confidentiality of information and the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf, as well other relevant State and Federal laws covering conflicts of interest and confidentiality of information.

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for someone else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

**NEED HELP WITH YOUR APPLICATION?** Visit [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov) or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-1076 and tell the customer service representative the language you need. We'll get you help at no cost to you. For more information, call 1-855-854-5363.

# Med-QUEST Responsibilities

Upon receipt of the HPE packet sent by the participating hospital, the Med-QUEST office shall:

- Log receipt of HPE packet and input information from HPE application and decision notice into the KOLEA system within 48 hours of receipt;
- Review DHS 1100 and determine eligibility for regular Medicaid or pend for verifications if needed;
- Upon receipt of required verifications, complete eligibility determination for regular Medicaid.
- Send appropriate Medicaid approval or denial notice to HPE beneficiary and a copy to HPE hospital staff who submitted the HPE packet
- Terminate HPE benefits pursuant to hospital PE period from date the eligibility determination for regular Medicaid is determined.
- If an HPE application is received with no DHS 1100 attached, input information in KOLEA, and terminate HPE effective the last day of the month following the month of HPE application.

# Connecting to Full Medicaid Coverage Outside the Hospital

Individuals can also apply for full Medicaid coverage as follows:

- Online at [mybenefits.Hawaii.gov](http://mybenefits.Hawaii.gov) or by calling 1-877-628-5076;
- In-person at the nearest Med-QUEST Eligibility Branch office;
- By mailing the paper application to the Med-QUEST Eligibility Branch office closest to their home;
- By faxing the paper application to 587-3543; or
- By calling Medicaid customer service on Oahu: 524-3370 , TDD: 692-7182, Neighbor Islands : 1-800-316-8005, TDD: 1-800-603-1201



# Contact Information

For questions or more information on Hawaii's Hospital Presumptive Eligibility policies, providers may contact:

Policy and Program Development Office

Phone: 808-692-8058, Fax: 808-692-8173

Information is also available on the Department's website:

[www.Med-QUEST.us](http://www.Med-QUEST.us)- Program information



# Medicaid Eligibility

OMB Control Number 0938-1148  
OMB Expiration date: 10/31/2014

42 CFR 435.110  
1902(a)(10)(A)(i)(I)  
1931(b) and (d)

**Parents and Other Caretaker Relatives -** Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

Options relating to the definition of caretaker relative (select any that apply):

The definition of caretaker relative includes the domestic partner of the parent or other caretaker relative, even after the partnership is terminated.

Definition of domestic partner:

The definition of caretaker relative includes other relatives of the child based on blood (including those of half-blood), adoption or marriage.

Description of other relatives:

The definition of caretaker relative includes any adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

Options relating to the definition of dependent child (select the one that applies):

The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.

The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):



# Medicaid Eligibility

Have household income at or below the standard established by the state.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

Income standard used for this group

Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.



Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.



The state's maximum income standard for this eligibility group is:

The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:



# Medicaid Eligibility

A percentage of the federal poverty level:  %

The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

Other dollar amount

Income standard chosen:

Indicate the state's income standard used for this eligibility group:

The minimum income standard

The maximum income standard

The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.

Another income standard in-between the minimum and maximum standards allowed

There is no resource test for this eligibility group.

Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Yes  No

## PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



# Medicaid Eligibility

OMB Control Number 0938-1148  
OMB Expiration date: 10/31/2014

42 CFR 435.116  
1902(a)(10)(A)(i)(III) and (IV)  
1902(a)(10)(A)(ii)(I), (IV) and (IX)  
1931(b) and (d)  
1920

**Pregnant Women** - Women who are pregnant or post-partum, with household income at or below a standard established by the state.

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

Yes  No

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

Income standard used for this group

Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

Yes  No

Enter the amount of the minimum income standard (no higher than 185% FPL):  % FPL

Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant

women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

The state's maximum income standard for this eligibility group is:

The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.



# Medicaid Eligibility

- The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- 185% FPL

The amount of the maximum income standard is:  % FPL

Income standard chosen

Indicate the state's income standard used for this eligibility group:

- The minimum income standard
- The maximum income standard
- Another income standard in-between the minimum and maximum standards allowed.

There is no resource test for this eligibility group.

Benefits for individuals in this eligibility group consist of the following:

- All pregnant women eligible under this group receive full Medicaid coverage under this state plan.
- Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

- Yes  No

### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



# Medicaid Eligibility

OMB Control Number 0938-1148  
OMB Expiration date: 10/31/2014

42 CFR 435.118  
1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)  
1902(a)(10)(A)(ii)(IV) and (IX)  
1931(b) and (d)

**Infants and Children under Age 19 - Infants and children under age 19 with household income at or below standards established by the state based on age group.**

The state attests that it operates this eligibility group in accordance with the following provisions:

Children qualifying under this eligibility group must meet the following criteria:

Are under age 19

Have household income at or below the standard established by the state.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

Income standard used for infants under age one

Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

Yes    No

Enter the amount of the minimum income standard (no higher than 185% FPL):  % FPL

Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.



The state's maximum income standard for this age group is:

The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.



## Medicaid Eligibility

- The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- 185% FPL

Enter the amount of the maximum income standard:  % FPL

Income standard chosen

The state's income standard used for infants under age one is:

The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

- Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

Income standard for children age one through age five, inclusive

Minimum income standard





# Medicaid Eligibility

The minimum income standard used for this age group is 133% FPL.

**Maximum income standard**

The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.



The state's maximum income standard for children age one through five is:

The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard:  % FPL

**Income standard chosen**

The state's income standard used for children age one through five is:

**The maximum income standard**

If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.



# Medicaid Eligibility

- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

- Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

**Income standard for children age six through age eighteen, inclusive**

**Minimum income standard**

The minimum income standard used for this age group is 133% FPL.

**Maximum income standard**

- The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.



The state's maximum income standard for children age six through eighteen is:

- The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

- The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

- The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

- The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

- 133% FPL

**Income standard chosen**

The state's income standard used for children age six through eighteen is:



# Medicaid Eligibility

The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children),

- 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children),

- 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-

- equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-

- equivalent percent of FPL.

- Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

There is no resource test for this eligibility group.

Presumptive Eligibility

The state covers children when determined presumptively eligible by a qualified entity.

- Yes  No

## PRA Disclosure Statement

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# Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

1902(a)(10)(A)(i)(VIII)  
42 CFR 435.119

The state covers the Adult Group as described at 42 CFR 435.119.

Yes  No

**Adult Group - Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.**

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Have attained age 19 but not age 65.

Are not pregnant.

Are not entitled to or enrolled for Part A or B Medicare benefits.

Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

Have household income at or below 133% FPL.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

There is no resource test for this eligibility group.

Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is

receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

Under age 19, or

A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:

Under age 20

Under age 21

**Presumptive Eligibility**

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Yes  No



# Medicaid Eligibility

## PRA Disclosure Statement

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# Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

42 CFR 435.150  
1902(a)(10)(A)(i)(IX)

**Former Foster Care Children - Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care when they turned age 18 or aged out of foster care.**

The state attests that it operates this eligibility group under the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Are under age 26.

Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

Were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state's state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state's or Tribe's foster care program.

The state elects to cover children who were in foster care and on Medicaid in any state at the time they turned 18 or aged out of the foster care system.

Yes  No

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Yes  No

## PRA Disclosure Statement

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# Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

1902(a)(10)(A)(ii)(XX)  
1902(hh)  
42 CFR 435.218

**Individuals above 133% FPL** - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218.

Yes  No

### PRA Disclosure Statement

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# Medicaid Eligibility

OMB Control Number 0938-1148  
OMB Expiration date: 10/31/2014

42 CFR 435.220  
1902(a)(10)(A)(ii)(I)

**Optional Coverage of Parents and Other Caretaker Relatives** - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220.

Yes    No

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Would be eligible under the state plan for the mandatory eligibility group, Parents and Other Caretaker Relatives, except for income.

Have household income at or below the standard established by the state.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

Income standard used for this group

The state covered this optional eligibility group under its state plan as of March 23, 2010, December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes    No

Minimum income standard

The income standard used for this eligibility group must exceed the income standard established for the mandatory Parents and Other Caretaker Relatives eligibility group (42 CFR 435.110). Please refer as necessary to S25 Parents and Other Caretaker Relatives for the income standard chosen for that group.

Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for  optionally eligible parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

The state's maximum income standard for this eligibility group is:

The state's effective income level for optionally eligible parents and other caretaker relatives under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

The state's effective income level for optionally eligible parents and other caretaker relatives under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.





# Medicaid Eligibility

The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

A percentage of the federal poverty level:  %

The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. If this standard has not been completed in S14 AFDC Income Standards, complete and submit it with this eligibility group. If it has already been completed, refer to it as necessary.

The state's TANF payment standard, converted to a MAGI-equivalent standard. If this standard has not been completed in S14 AFDC Income Standards, complete and submit it with this eligibility group. If it has already been completed, refer to it as necessary.

Other dollar amount

Income standard chosen

Indicate the state's income standard used for this eligibility group:

The maximum income standard

Another income standard in-between the minimum and maximum standards allowed.

The state's AFDC payment standard in effect as of July 16, 1996, not converted to a MAGI-equivalent standard. If this standard has not been completed in S14 AFDC Income Standards, complete and submit it with this eligibility group. If it has already been completed, refer to it as necessary.

The state's TANF payment standard, not converted to a MAGI-equivalent standard. If this standard has not been completed in S14 AFDC Income Standards, complete and submit it with this eligibility group. If it has already been completed, refer to it as necessary.

If not chosen as the maximum income standard, the state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. If this standard has not been completed in S14 AFDC Income Standards, complete and submit it with this eligibility group. If it has already been completed, refer to it as necessary.

If not chosen as the maximum income standard, the state's TANF payment standard, converted to a MAGI-equivalent standard. If this standard has not been completed in S14 AFDC Income Standards, complete and submit it with this eligibility group. If it has already been completed, refer to it as necessary.

Other income standard in-between the minimum and the maximum standards allowed.

The amount of the income standard for this eligibility group is:

A percentage of the federal poverty level:  %

Other dollar amount

There is no resource test for this eligibility group.



# Medicaid Eligibility

## PRA Disclosure Statement

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# Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

## Eligibility Groups - Options for Coverage

S52

### Reasonable Classification of Individuals under Age 21

42 CFR 435.222

1902(a)(10)(A)(ii)(I)

1902(a)(10)(A)(ii)(IV)

**Reasonable Classification of Individuals under Age 21** - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222.

Yes  No

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must qualify under a reasonable classification by meeting the following criteria:

Be under age 21, or a lower age, as defined within the reasonable classification.

Have household income at or below the standard established by the state, if the state has an income standard for the reasonable classification.

Not be eligible and enrolled for mandatory coverage under the state plan.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

Yes  No

The state also covered at least one reasonable classification under this group in the Medicaid state plan as of March 23, 2010 with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

Yes  No

#### Reasonable Classifications Previously Covered

The state elects the option to include in this eligibility group reasonable classifications that were covered under the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes  No

The state covers all children under a specified age limit, no higher than any age limit and/or income standard covered in the state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, provided the income standard is higher than the current mandatory income standard for the individual's age. Higher income standards may include the disregard of all income.

Yes  No



# Medicaid Eligibility

The state covers reasonable classifications of children that were covered under the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013 with an income standard higher than the current mandatory income standard for the age group.

Yes  No

The previously covered reasonable classifications to be included are:

### Previously Covered Reasonable Classifications Included

### Reasonable Classifications of Children S11

- Individuals for whom public agencies are assuming full or partial financial responsibility.
- Individuals in adoptions subsidized in full or part by a public agency
- Individuals in nursing facilities, if nursing facility services are provided under this plan
- Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan
- Other reasonable classifications

	Name of classification	Description	Age Limit	
+	Section 2101(f) - Like Children	2101(f)-Like Children: Children under age 19 years who were enrolled in Medicaid on December 31, 2013 and would otherwise become ineligible for Medicaid at their first determination using Modified Adjusted Gross Income (MAGI) based methodologies solely due to the loss of income disregards will remain Medicaid eligible until their next redetermination using MAGI methodologies.	Under age 19	X

Enter the income standard used for these classifications (which may be no higher than the highest standard used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013).

[Click here once S11 form above is complete to view the income standards form.](#)

### Section 2101(f) of ACA

Income standard used

Minimum income standard

The minimum income standard for this classification of children must exceed the lowest income standard chosen for children under this age under the Infants and Children under Age 19 eligibility group.

Maximum income standard



# Medicaid Eligibility

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes     No

The state's maximum standard for this classification of children is no income test (all income is disregarded).

Income standard chosen

Individuals qualify under this classification under the following income standard:

This classification does not use an income test (all income is disregarded).

Another income standard higher than the minimum income standard.

## New reasonable classifications covered

If the state has not elected to cover the Adult Group (42 CFR 435.119), it may elect to cover additional new age groups or reasonable classifications that have not been covered previously. If the state covers the Adult Group, this additional option is not available, as the standard for the new age groups or classifications is lower than that used for mandatory coverage.

The state does not cover the Adult Group and elects the option to include in this eligibility group additional age groups or reasonable classifications that have not been covered previously in the state plan or under a Medicaid 1115 Demonstration. Any additional age groups or reasonable classifications not previously covered are restricted to the AFDC income standard from July 16, 1996, not converted to a MAGI-equivalent standard.

Yes     No

There is no resource test for this eligibility group.

## PRA Disclosure Statement

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# Medicaid Eligibility

OMB Control Number 0938-1148  
OMB Expiration date: 10/31/2014

42 CFR 435.227  
1902(a)(10)(A)(ii)(VIII)

**Children with Non IV-E Adoption Assistance** - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

Yes    No

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

The state adoption agency has determined that they cannot be placed without Medicaid coverage because of special needs for medical or rehabilitative care;

Are under the following age (see the Guidance for restrictions on the selection of an age):

- Under age 21
- Under age 20
- Under age 19
- Under age 18

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes    No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

Yes    No

Individuals qualify under this eligibility group if they were eligible under the state's approved state plan prior to the execution of the adoption agreement.

The state used an income standard or disregarded all income for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes    No

There is no resource test for this eligibility group.

## PRA Disclosure Statement

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TN No: 13-0007-MM1  
Hawaii

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S53-1

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# Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

1902(a)(10)(A)(ii)(XIV)  
42 CFR 435.229 and 435.4  
1905(u)(2)(B)

**Optional Targeted Low Income Children** - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.

Yes  No

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must not be eligible for Medicaid under any mandatory eligibility group.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes  No

The state also covered this eligibility group in the state plan as of March 23, 2010.

Yes  No

Until October 1, 2019, states must include at least those individuals covered as of March 23, 2010, but may cover additional individuals. Effective October 1, 2019, states may reduce or eliminate coverage for this group.

Individuals are covered under this eligibility group, as follows:

All children under age 18 or 19 are covered:

Under age 19

Under age 18

The reasonable classification of children covered is:

Income standard used for this classification

Minimum income standard

The income standard for this classification of children must exceed the lowest income standard chosen for children in the age group selected above, under the mandatory Infants and Children under Age 19 eligibility group.

Maximum income standard



# Medicaid Eligibility

- The state certifies that it has submitted and received approval for its converted income standard(s) for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.



The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

- The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for this classification of children under the Medicaid State Plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for this classification of children under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for this classification of children under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- 200% FPL.
- A percentage of the FPL which may exceed the Medicaid Applicable Income Level, defined in section 2110(b)(4) of the Act, but by no more than 50 percentage points.
- The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

% FPL

- Income standard chosen, which must exceed the minimum income standard

Individuals qualify under the following income standard:

- The maximum income standard.
- The state's effective income level for this eligibility group under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
  - If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective income level for this eligibility group under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
  - If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective income level for this eligibility group under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
  - If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective income level for this eligibility group under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
  - If higher than the effective income level used under the state plan as of March 23, 2010, 200% FPL.





# Medicaid Eligibility

- If higher than the effective income level used under the state plan as of March 23, 2010, a percentage of the
- FPL which may exceed the Medicaid Applicable Income Level, defined in section 2110(b)(4) of the Act, but by no more than 50 percentage points.
  - Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this eligibility group in the state plan as of March 23, 2010.

The income standard for this eligibility group is:  % FPL

There is no resource test for this eligibility group.

Presumptive Eligibility

Presumptive eligibility for this group depends upon the selection of presumptive eligibility for the Infants and Children under Age 19 eligibility group. If presumptive eligibility is done for that group, it is done for this group under the same provisions.

## PRA Disclosure Statement

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# Medicaid Eligibility

OMB Control Number 0938-1148  
OMB Expiration date: 10/31/2014

1902(a)(10)(A)(ii)(XII)  
1902(z)

**Individuals with Tuberculosis** - The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services.

Yes  No

### PRA Disclosure Statement

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# Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

42 CFR 435.226  
1902(a)(10)(A)(ii)(XVII)

**Independent Foster Care Adolescents** - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226.

Yes    No

### PRA Disclosure Statement

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# Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

1902(a)(10)(A)(ii)(XXI)  
42 CFR 435.214

**Individuals Eligible for Family Planning Services** - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214.

Yes  No

### PRA Disclosure Statement

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SI: converted thresholds  
 date: 09-APR-2013

population/type	applicant type	citation	unit size	original standard	converted standard
Family - 1988	applicant	AFDC 5/1/1988	1	\$327	\$493
			2	\$430	\$653
			3	\$515	\$795
			4	\$601	\$938
			5	\$689	\$1,083
			6	\$780	\$1,232
			7	\$882	\$1,391
			8	\$942	\$1,508
			9	\$1,000	\$1,623
			10	\$1,059	\$1,739
			11	\$1,119	\$1,857
			12	\$1,179	\$1,974
			13	\$1,239	\$2,091
			14	\$1,299	\$2,208
			15	\$1,359	\$2,325
		addon	\$60	\$110	
ben 4 months	AFDC 5/1/1988	AFDC 5/1/1988	1	\$327	\$397
			2	\$430	\$524
			3	\$515	\$633
			4	\$601	\$744
			5	\$689	\$856
			6	\$780	\$971
			7	\$882	\$1,097
			8	\$942	\$1,181
			9	\$1,000	\$1,263
			10	\$1,059	\$1,347
			11	\$1,119	\$1,431
			12	\$1,179	\$1,515
			13	\$1,239	\$1,599
			14	\$1,299	\$1,683
			15	\$1,359	\$1,767
		addon	\$60	\$81	
ben 8 months	AFDC 5/1/1988	AFDC 5/1/1988	1	\$327	\$388
			2	\$430	\$512
			3	\$515	\$618
			4	\$601	\$725
			5	\$689	\$834
			6	\$780	\$947
			7	\$882	\$1,070
			8	\$942	\$1,151
			9	\$1,000	\$1,230
			10	\$1,059	\$1,310
			11	\$1,119	\$1,391
			12	\$1,179	\$1,472
			13	\$1,239	\$1,553
			14	\$1,299	\$1,634
			15	\$1,359	\$1,715
		addon	\$60	\$78	
Family - 1996	applicant	AFDC 7/16/1996	1	\$418	\$630
			2	\$565	\$851
			3	\$712	\$1,071
			4	\$859	\$1,291
			5	\$1,006	\$1,511
			6	\$1,153	\$1,732
			7	\$1,300	\$1,952
			8	\$1,446	\$2,171
			9	\$1,593	\$2,392
			10	\$1,740	\$2,612
			11	\$1,887	\$2,832
			12	\$2,034	\$3,052
			13	\$2,181	\$3,273
			14	\$2,328	\$3,493
			15	\$2,475	\$3,713
		addon	\$146	\$210	
ben 4 months	AFDC 7/16/1996	AFDC 7/16/1996	1	\$418	\$479
			2	\$565	\$647
			3	\$712	\$815

			4	\$859	\$983
			5	\$1,006	\$1,151
			6	\$1,153	\$1,319
			7	\$1,300	\$1,487
			8	\$1,446	\$1,654
			9	\$1,593	\$1,823
			10	\$1,740	\$1,991
			11	\$1,887	\$2,159
			12	\$2,034	\$2,327
			13	\$2,181	\$2,495
			14	\$2,328	\$2,663
			15	\$2,475	\$2,831
			addon	\$146	\$164
	ben 8 months	AWDC 7/16/1996	1	\$418	\$469
			2	\$565	\$634
			3	\$712	\$799
			4	\$859	\$964
			5	\$1,006*	\$1,129
			6	\$1,153	\$1,293
			7	\$1,300	\$1,458
			8	\$1,446	\$1,622
			9	\$1,593	\$1,787
			10	\$1,740	\$1,951
			11	\$1,887	\$2,116
			12	\$2,034	\$2,281
			13	\$2,181	\$2,446
			14	\$2,328	\$2,610
			15	\$2,475	\$2,775
			addon	\$146	\$161
Pregnant and children <1		1902 (a) (10) (A) (i) (IV) mandatory poverty-level related pregnant women covered for pregnancy-related services and mandatory poverty-level related infant			
				185% FPL	191% FPL
Child 1-5		1902 (a) (10) (A) (i) (VI) mandatory poverty-level related children aged 1-5			
				133% FPL	139% FPL
Child 6-18		1902 (a) (10) (A) (i) (VI) mandatory poverty-level related children aged 6-18			
				100% FPL	105% FPL
Adult 19-64		1115			
				200% FPL	208% FPL
Children <19 (>150/133/100% F		M-CHIP children <19 1902 (a) (10) (A) (ii) (X IV)			
				300% FPL	308% FPL

**SUPERSEDING PAGES OF  
STATE PLAN MATERIAL**

**TRANSMITTAL NUMBER:**

13-0007-MM3

**STATE:**

Hawaii

**PAGE NUMBER OF THE PLAN SECTION OR  
ATTACHMENT:**

S10 - MAGI Income Methodology

**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):**

Notwithstanding any other provisions of the Hawaii Medicaid State Plan, the financial eligibility methodologies described in State Plan Amendment HI-13-0007-MM3 will apply to all MAGI-based eligibility groups covered under Hawaii's Medicaid State Plan. The MAGI financial methodologies set forth in 42 CFR §435.603 apply to everyone except those individuals described at 42 CFR §435.603(j) for whom MAGI-based methods do not apply. This State Plan Amendment supersedes the current financial eligibility provisions of the Medicaid State Plan only with respect to the MAGI-based eligibility groups.



# Medicaid Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: 15 - - 0002

Expiration date: 10/31/2014

## MAGI-Based Income Methodologies

S10

1902(e)(14)  
42 CFR 435.603

- The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- The pregnant woman is counted just as herself.
- The pregnant woman is counted as herself, plus one.
- The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- Current monthly household income and family size
- Projected annual household income and family size for the remaining months of the current calendar year

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- Include a prorated portion of a reasonably predictable increase in future income and/or family size.
- Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

Yes  No





# Medicaid Eligibility

The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

Age 19

Age 19, or in the case of full-time students, age 21

### PRA Disclosure Statement

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V.20140415



# Medicaid Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: 14 - - 0008

Expiration date: 10/31/2014

## General Eligibility Requirements Eligibility Process S94

42 CFR 435, Subpart J and Subpart M

### Eligibility Process

- The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

#### Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

- The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

- An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

- An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

- The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

- An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

- Yes
- No



# Medicaid Eligibility

Indicate the other electronic means below:

	Name of Method	Description	
<input checked="" type="checkbox"/>	Facsimile	The agency accepts applications received via facsimile.	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	E-mail	The agency accepts applications received via e-mail.	<input checked="" type="checkbox"/>

The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

### Redetermination Processing

Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

Once every 12 months

Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

Once every 12 months

Once every 6 months

Other, more often than once every 12 months

### Coordination of Eligibility and Enrollment

The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

## Application for Health Coverage & Help Paying Costs

THINGS TO KNOW



### Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)



### Who can use this application?

- Use this application to apply for you or anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.



### Apply faster online

- Apply faster online at [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov).
- If you want to purchase insurance without help, apply directly at [hawaiihealthconnector.com](http://hawaiihealthconnector.com)



### What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family



### Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, go to [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov).



### What happens next?

Send your complete, signed application to the address on page 7. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov) or call 1-877-628-5076. Filling out this application doesn't mean you have to buy health coverage.



### Get help with this application

- **Online:** [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov)
- **Phone:** Call the Contact Center at 1-877-628-5076 for assistance with completing and submitting an application or getting information on the status of your application.
- **In person:** There may be counselors in your area who can help. Visit our website or call 1-877-628-5076 for more information.
- **Medicaid:** For specific questions on Medicaid/CHIP eligibility, call 1-888-764-7586.



This is an important letter from the Department of Human Services. Please call the phone number located on the letter. When you call, you will be asked what language you speak and your call will be put on hold for an interpreter. You can also call 1-888 - 764-7586 for all DHS services.	<b>English</b>
這是一封從人類服務部門發出的重要信件。請撥打信上的電話號碼。當你打電話時，你將會被詢問你講什麼語言，您的通話將被擱置直到接通翻譯服務。其他人類服務部門的服務，您可以致電到 1- 888 - 764-7586。	<b>Cantonese</b>
Ei taropwe mi auchchea seni ewe putain tumwunun aramas (Department of Human Services). Kose mwochen kokkori na nampan foon won na taropwe. Nupwen omw kokko, repwe eisinuk menni kkapas ke sine pwe repwe kkutta ngonuk emon choon chiaku. Ka pwan tongeni kokkori 1-888-764-7586 ren meinisin aninnis seni DHS.	<b>Chuukese</b>
Ceci est une lettre importante du Department of Human Services (DHS). S'il vous plaît, faire un appel téléphonique au numéro de téléphone situé sur la lettre. Lorsque vous téléphonez, quelqu'un va vous demander quelle langue vous parlez, et votre appel sera mis en attente pour un interprète. Vous pouvez aussi téléphoner 1-888 - 764-7586 pour tous les services de DHS.	<b>French</b>
Dies ist ein wichtiger Brief von der Abteilung Menschlicher Dienste (DHS). Bitte rufen Sie die Telefonnummer, die auf dem Brief gefunden wurde. Wenn Sie rufen, werden Sie gefragt werden, welche Sprache Sie sprechen, und Ihr Anruf wird auf Wartestellung für einen Dolmetscher geschaltet werden. Sie können 1-888-764-7586 für alle DHS Dienste auch rufen.	<b>German</b>
He leka ko'iko'i keia mai ka 'Oihana Lawelawe Kanaka (Department of Human Services). E kelepona mai i ka helu kelepona ma luna o ka leka. Ke kelepona 'oe, e ninau 'ia ana 'oe he aha kau 'olelo 'oiwi a laila e kali 'oe a loa'a ke kanaka mahele 'olelo. Hiki pu ia 'oe ke kelepona i 1-888-764-7586 no na lawelawe a pau a ka 'Oihana Lawelawe Kanaka (DHS).	<b>Hawaiian</b>
Daytoy ket importante nga surat nga naggapu iti Department of Human Services. Pangaasi nga tawagan yo iti numero iti telepono nga nakakabil iti daytoy nga surat. Nu umawag kayo, saludsuden da nu anya iti panagsasao yo ket urayen yo nga maiyallatiw iti tawag yo iti interpreter. Mabalín kayo nga umawayg iti 1-888-764-7586 para kadagiti amin nga serbisyo iti DHS.	<b>Ilocano</b>
ハワイ州人道的奉仕局からの大切なお知らせです。この紙面に書かれている番号にお電話ください。電話をされた時に、貴方がどの言語を話されているかを聞かれます、通訳に接続されるまでしばらくお待ちください。DHSのどのサービスにも、この電話番号 1 - 8 8 8 - 7 6 4 - 7 5 8 6 で対応いたします。	<b>Japanese</b>
인간 서비스 부서에서 보내는 중요한 편지입니다. 이편지에 기재된 전화번호로 전화를 하시오. 당신이 전화를 할때 당신이 사용하는 언어를 물어것이고 그언어의 통역인에게 연결할것 입니다. 당신은 모든 인간 서비스 부서(디에이치에스)에 도움을 받기 위해서 1-888-764-7586 로 전화 할수 있습니다	<b>Korean</b>
这是一封从人类服务部门发出的重要信件。请拨打信上的电话号码。当你打电话时，你将会被询问你讲什么语言，您的通話將被擱置直到接通翻譯服務。其他人類服務部門的服務，您可以致電到 1-888 - 764-7586。	<b>Mandarin</b>
Juon in kojela im elap an aurok im ej itok jen ra eo an department of human services. Jouij im call e nomba in im ej bed ilo pepa in ak letta in. Ne koj call, renej kajitok ibbem kin kain kajin eo am im elikin am ba renej ba kwon kottar bwe ren lewoj juon am ri okok. Komaron call 1-888-764-7586 non aolepen ra ko kajojo ilo DHS services.	<b>Marshallese</b>
O se fa'asilasilaga ta'ua lenei mai le Ofisa o le Human Services. Fa'amolemole, vala'au mai i le numera lea o lo'o i luga o lenei tusi. A e vala'au mai, o le a fesili atu po'o le a le gagana e te mo'omia, ona tu'u sa'o lea o lau telefoni i se tagata e mafai ona fesoasoani ia oe. E mafai fo'i ona e vala'au i le number 1-888-764-7586 mo nisi 'au'aunaga mai lenei Ofisa.	<b>Samoan</b>
Ésta es una carta importante de la Sección de Servicios Humanos (DHS). Por favor llame el número de teléfono localizado en la carta. Cuando usted llama, usted se preguntará qué idioma usted habla y su llamada se pondrá en espera para un intérprete. Usted también puede llamar 1-888 - 764-7586 para todos los servicios de DHS.	<b>Spanish</b>
Ito ay mahalaga na sulat na galling sa Department of Human Services. Mangyaring tawagan ang numero na nakalagay sa sulat na ito. Kung kayo ay tatawag, tatanungin kung ano ang iyong wika at hintayin ninyo hanggat may sumagot na tagasalin. Pwede ninyong tumawag sa 1-888-764-7586 para sa lahat ng serbisyo sa DHS.	<b>Tagalog</b>
Ko e tohi mahu'inga eni mei he Potungae Ngaue Ma'ae Kakai. Kataki 'o telefoni ki he fika 'oku ha 'i he tohi ni. 'E fehu'i atu pe ko e ha e fa'ahinga lea 'oku ke lea'aki 'i he taimi te ke ta mai ai pea tnitokoe ke tali kae 'oua kuo ma'u ha toko taha fakatonu lea. Te ke lava 'o ta ki he ki he ngaahi tokoni kotoa 'a e DHS.	<b>Tongan</b>
Đây là lá thư quan trọng từ các Bộ Phục Vụ Nhân Dân (DHS). Làm ơn gọi số điện thoại nằm trên lá thư. Khi bạn gọi, bạn sẽ được hỏi ngôn ngữ nào bạn nói và cú điện thoại của bạn sẽ chờ người thông dịch. Đồng thời bạn cũng có thể gọi số 1-888-764-7586 cho các phục vụ DHS.	<b>Vietnamese Việt Nam</b>
Kini importante nga sulat gikan sa Department of Human Services (DHS). Palihug tawagi ang numero sa maong telepono nga nahimutang sa sulat. Sa imong pagtawag, ikaw pangutan-on kun unsa ang imong pinulongan ug ang imong tawag ilang ipahulat para sa usa ka taghubad sa pinulongan. Mahimo usab nga imong tawagan ang 1-888-764-7586 para sa tanang mga serbisyo sa DHS.	<b>Visayan</b>



# STEP 1

## Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name	Middle name	Last name	Suffix
2. Home address (Leave blank if you don't have one.)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. County
14. Phone number ( ) -		15. Other phone number ( ) -	
16. Do you want to get information about this application by email? Yes <input type="checkbox"/> No <input type="checkbox"/> Email address: _____			
17. What is your preferred spoken language (if not English)?		18. What is your preferred written language (if not English)?	
19. How many family members live with you?		20. Is any family member you usually live with incarcerated (detained or jailed) or residing in the Hawaii State Hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list their name(s):	

# STEP 2

## Tell us about your family.

### Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

#### DO Include:

- Yourself
- Your spouse
- Your children under 19 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 19 who you take care of and lives with you

#### You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 19)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

**Complete Step 2 for each person in your family.** Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.



## STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name	Middle name	Last name	Suffix	2. Relationship to you? SELF
---------------	-------------	-----------	--------	---------------------------------

3. Date of birth (mm/dd/yyyy)   /   /     4. Gender  Male  Female

5. Social Security number (SSN)    -   -

**We need this if you want health coverage and have an SSN.** Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit [socialsecurity.gov](http://socialsecurity.gov). TTY users should call 1-800-325-0778.

### 6. Do you plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

Yes. If yes, please answer questions a–c.  No. If no, skip to question c.

a. Will you file jointly with a spouse?  Yes  No

If yes, name of spouse: \_\_\_\_\_

b. Will you claim any dependents on your tax return?  Yes  No

If yes, list name(s) of dependents: \_\_\_\_\_

c. Will you be claimed as a dependent on someone's tax return?  Yes  No

If yes, please list the name of the tax filer: \_\_\_\_\_

How are you related to the tax filer? \_\_\_\_\_

7. Are you pregnant?  Yes  No If yes, how many babies are expected during this pregnancy? \_\_\_\_\_ Expected Due Date \_\_\_\_\_

### 8. Do you need health coverage?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

Yes. If yes, answer all the questions below.



No. If no, SKIP to the income questions on page 3. Leave the rest of this page blank.



9. Do you have a disability that will last more than twelve (12) months?  Yes  No

a. Do you currently receive long term care nursing services:  Yes, in a nursing facility  Yes, in my home or in the community  No

b. Have you received long term care nursing services in the last three (3) months?  Yes  No If yes, what date(s)? \_\_\_\_\_

c. Do you think you need long term care nursing services now?  Yes  No

d. Do you receive Supplemental Security Income (SSI)?  Yes  No

10. Did you receive any medical services in the past ten (10) calendar days immediately prior to the date of application?

Yes  No If yes, what date(s)? \_\_\_\_\_

11. Are you a U.S. citizen or U.S. national?  Yes If yes, skip to Question 13.  No

12. If you aren't a U.S. citizen or U.S. national, please provide the information below.

a. Immigration document type \_\_\_\_\_

b. Document ID number \_\_\_\_\_

c. When did you enter the U.S.? \_\_\_\_\_

d. Are you a citizen of the Federated State of Micronesia, the Republic of the Marshall Islands, and Palau?  Yes  No

e. Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military?  Yes  No

13. Are you the primary or one of the primary person(s) taking care of a child under age 19 years that lives with you?  Yes  No

14. Were you in foster care at age 18 or older in Hawaii?  Yes  No

15. Are you a full-time student?  Yes  No

16. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican  Mexican American  Chicano/a  Puerto Rican  Cuban  Other \_\_\_\_\_

17. Race (OPTIONAL – check all that apply.)

White  Black or African American  Filipino  Vietnamese  Guamanian or Chamorro  
 Asian Indian  American Indian or Alaska Native  Japanese  Other Asian  Other Pacific Islander  
 Chinese  Native Hawaiian  Korean  Samoan  Other \_\_\_\_\_



# STEP 2: PERSON 1 (Continue with yourself)

## Current Job & Income Information

### Employed

If you're currently employed, tell us about your income. Start with question 18.

### Not employed

Skip to question 28.

### Self-employed

Skip to question 27.

### CURRENT JOB 1:

18. Employer name and address

19. Employer phone number

( ) -

20. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly

\$ \_\_\_\_\_

21. Average hours worked each WEEK

### CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address

23. Employer phone number

( ) -

24. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly

25. Average hours worked each WEEK

26. In the past year, did you: Change jobs Stop working Start working fewer hours None of these

27. If self-employed, answer the following questions:

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

\$ \_\_\_\_\_

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

**NOTE:** You don't need to tell us about child support or veteran's payment.

- |  |          |                  |  |          |                  |
|--|----------|------------------|--|----------|------------------|
| <input type="checkbox"/> Unemployment        | \$ _____ | How often? _____ | <input type="checkbox"/> Net farming/fishing | \$ _____ | How often? _____ |
| <input type="checkbox"/> Pensions            | \$ _____ | How often? _____ | <input type="checkbox"/> Net rental/royalty  | \$ _____ | How often? _____ |
| <input type="checkbox"/> Social Security     | \$ _____ | How often? _____ | <input type="checkbox"/> Other income        | \$ _____ | How often? _____ |
| <input type="checkbox"/> Retirement accounts | \$ _____ | How often? _____ | Type: _____                                  |          |                  |
| <input type="checkbox"/> Alimony received    | \$ _____ | How often? _____ |  |          |                  |

29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

**NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

Alimony paid	\$ _____	How often? _____	Other deductions	\$ _____	How often? _____
Student loan interest	\$ _____	How often? _____	Type:	_____	

30. **NET YEARLY INCOME:** Complete if your net income changes a lot from month to month.

If you don't expect changes to your monthly income, skip to the next person.



Your total income this year	Your total income next year (if you think it will be different)
\$ _____	\$ _____

**THANKS! This is all we need to know about you.**

If there is 2 or more people to include, please make copy (ies) of STEP 2: PERSON 2 (Pages 4 and 5) and Complete.





# STEP 2: PERSON 2

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name	Middle name	Last name	Suffix	2. Relationship to Person 1?
---------------	-------------	-----------	--------	------------------------------

3. Date of birth (mm/dd/yyyy)   /   /

4. Gender  Male  Female

5. Social Security number (SSN)    -   -

**We need this if you want health coverage and have an SSN.**

6. Does PERSON 2 live at the same address as you? **Yes** **No**  
 If no, list address: \_\_\_\_\_

7. Does PERSON 2 plan to file a federal income tax return NEXT YEAR?  
 (You can still apply for health insurance even if you don't file a federal income tax return.)

**Yes. If yes, please answer questions a–c. No. If no, skip to question c.**

a. Will PERSON 2 file jointly with a spouse? **Yes** **No**  
 If yes, name of spouse: \_\_\_\_\_

b. Will PERSON 2 claim any dependents on his/her return?  Yes  No  
 If yes, list name(s) of dependents: \_\_\_\_\_

c. Will PERSON 2 be claimed as a dependent on someone's tax return? **Yes** **No**  
 If yes, please list the name of the tax filer: \_\_\_\_\_  
 How is PERSON 2 related to the tax filer? \_\_\_\_\_

8. Is PERSON 2 pregnant?  Yes  No **If yes, how many babies are expected during this pregnancy?** \_\_\_\_\_ **Expected Due Date:** \_\_\_\_\_

9. Does PERSON 2 need health coverage?  
 (Even if they have insurance, there might be a program with better coverage or lower costs.)

**Yes. If yes, answer all the questions below.** **No. If no, SKIP to the income questions on page 5. Leave the rest of this page blank.**

10. Does PERSON 2 have a disability that will last more than twelve (12) months?  Yes  No

a. Does PERSON 2 currently receive long term care nursing services?  Yes, in a nursing facility  Yes, in my home or in the community  No

b. Has PERSON 2 received long term care services in the last three (3) months?  Yes  No **If yes, what date(s)?** \_\_\_\_\_

c. Does PERSON 2 need long term care nursing services now?  Yes  No

d. Does PERSON 2 receive Supplemental Security Income (SSI)?  Yes  No

11. Did PERSON 2 receive any medical services in the past ten (10) calendar days immediately prior to the date of application?  
 Yes  No **If yes, what date(s)?** \_\_\_\_\_

12. Is PERSON 2 a U.S. citizen or U.S. national?  Yes **If yes, skip to question 13.**  No

13. **If PERSON 2 isn't a U.S. citizen or U.S. national, please provide the information below.**

a. Immigration document type \_\_\_\_\_

b. Document ID number \_\_\_\_\_

c. When did PERSON 2 enter the U.S.? \_\_\_\_\_

d. Is PERSON 2 a citizen of the Federated States of Micronesia, the Republic of the Marshall Islands or Palau?  Yes  No

e. Is PERSON 2, or their spouse or parent, a veteran or an active-duty member of the U.S. military?  Yes  No

14. Is PERSON 2 the primary or one of the primary person(s) taking care of a child under age 19 years that lives with you?  Yes  No

15. Was PERSON 2 in foster care at age 18 or older in Hawaii?  Yes  No

16. Is PERSON 2 a full-time student?  Yes  No

17. **If Hispanic/Latino, ethnicity (OPTIONAL - check all that apply.)**  
 Mexican  Mexican American  Chicano/a  Puerto Rican  Cuban  Other \_\_\_\_\_

18. **Race (OPTIONAL—check all that apply.)**  
 White  Black or African American  Filipino  Vietnamese  Guamanian or Chamorro  
 Asian Indian  American Indian or Alaska Native  Japanese  Other Asian  Other Pacific Islander  
 Chinese  Native Hawaiian  Korean  Samoan  Other \_\_\_\_\_

**Now, tell us about any income from PERSON 2 on the back.**



# STEP 2: PERSON 2

## Current Job & Income Information

### Employed

If you're currently employed, tell us about your income. Start with question 19.

### Not employed

Skip to question 29.

### Self-employed

Skip to question 28.

### CURRENT JOB 1:

19. Employer name and address

20. Employer phone number

( ) -

21. Wages/tips (before taxes)    Hourly    Weekly    Every 2 weeks    Twice a month    Monthly

\$ \_\_\_\_\_

22. Average hours worked each WEEK

### CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

23. Employer name and address

24. Employer phone number

( ) -

25. Wages/tips (before taxes)    Hourly    Weekly    Every 2 weeks    Twice a month    Monthly

\$ \_\_\_\_\_

26. Average hours worked each WEEK

27. In the past year, did PERSON 2:    Change jobs    Stop working    Start working fewer hours    None of these

28. If self-employed, answer the following questions:

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

\$ \_\_\_\_\_

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

**NOTE:** You don't need to tell us about child support or veteran's payment.

- |  |          |                  |  |          |                  |
|--|----------|------------------|--|----------|------------------|
| <input type="checkbox"/> Unemployment        | \$ _____ | How often? _____ | <input type="checkbox"/> Net farming/fishing | \$ _____ | How often? _____ |
| <input type="checkbox"/> Pensions            | \$ _____ | How often? _____ | <input type="checkbox"/> Net rental/royalty  | \$ _____ | How often? _____ |
| <input type="checkbox"/> Social Security     | \$ _____ | How often? _____ | <input type="checkbox"/> Other income        | \$ _____ | How often? _____ |
| <input type="checkbox"/> Retirement accounts | \$ _____ | How often? _____ | Type: _____                                  |          |                  |
| <input type="checkbox"/> Alimony received    | \$ _____ | How often? _____ |  |          |                  |


30. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

**NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment (question 28b).

Alimony paid	\$ _____	How often? _____	Other deductions	\$ _____	How often? _____
Student loan interest	\$ _____	How often? _____	Type: _____		

31. **NET YEARLY INCOME:** Complete if PERSON 2 net income changes a lot from month to month.

If you don't expect changes to PERSON 2 monthly income, skip to the next section. 

PERSON 2's total income this year

\$ \_\_\_\_\_

PERSON 2's total income next year (if you think it will be different)

\$ \_\_\_\_\_

**THANKS! This is all we need to know about PERSON 2.**

If there are no more people to include, skip to next page. 



## STEP 3

### American Indian or Alaska Native (AI/AN) family member(s)

#### 1. Are you or is anyone in your family American Indian or Alaska Native?

Yes. If yes, go to Appendix B.

No. If No, skip to Step 4.

## STEP 4

### Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

#### 1. Does anyone have health coverage or health insurance other than Medicaid?

Yes. If yes, Check the type of coverage and write the person(s) name(s) on the line provided and additional information as appropriate.

Employer insurance \_\_\_\_\_

Name of health insurance: \_\_\_\_\_

Policy number: \_\_\_\_\_

Is this COBRA coverage?  Yes  No

Is this a retiree health plan?  Yes  No

Medicare \_\_\_\_\_

TRICARE \_\_\_\_\_

(Don't check if you have direct care or Line of Duty)

VA health care programs \_\_\_\_\_

Peace Corps \_\_\_\_\_

Other \_\_\_\_\_

Name of health insurance: \_\_\_\_\_

Policy number: \_\_\_\_\_

Is this a limited-benefit plan (like a school accident policy)?  Yes  No

No

#### 2. Is anyone listed on this application offered health coverage from a job?

(Check YES even if the coverage is from someone else's job, such as a parent or spouse.)

Yes. If yes, You'll need to complete and include Appendix A. Is this a state employee benefit plan? Yes No

No. If no, continue to Step 5.

#### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average [Insert Time (hours or minutes)] per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



# !!! SIGNATURE REQUIRED BELOW !!!

## STEP 5

### Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under state or federal law if I provide false and or untrue information.
- I understand that I must tell the Department of Human Services or the Hawaii Health Connector if anything changes (and is different than) what I wrote on this application. I can visit [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov) or call 1-877-628-5076 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I understand that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting [www.hhs.gov/ocr/office/file](http://www.hhs.gov/ocr/office/file).
- I understand the Department of Human Services and the Hawaii Health Connector will obtain information to verify eligibility with electronic databases and databases, to include but not limited to, the Internal Revenue Services (IRS), Social Security Administration (SSA), Department of Homeland Security (DHS) or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

### Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Hawaii Health Connector to use income data, including information from tax returns. The Hawaii Health Connector will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

- 5 years (the maximum number of years allowed), or for a shorter number of years:  
 4 years    3 years    2 years    1 year    Don't use information from tax returns to renew my coverage.

### If anyone on this application is eligible for Medicaid

- I am assigning the Department of Human Services, my rights to payments for medical care from any third party, which may include but not limited to, other health insurance or legal settlement. I am also assigning the Department of Human Services, my rights to pursue and get medical support from a spouse or parent. I will cooperate in obtaining third party payments.
- Does any child on this application have a parent living outside of the home?  Yes  No **If yes,** I understand I will be asked to cooperate with the Department of Human Services and the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.
- I agree to cooperate with the Department of Human Services, Federal Quality Control reviewers or auditors if my case is selected for a review.

### My right to appeal

If I think the Department of Human Services or the Hawaii Health Connector has made a mistake, I can appeal its decision. To appeal means to tell someone at the Department of Human Services or the Hawaii Health Connector that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting someone at 1-877-628-5076. I know that I can be represented in the process by someone other than myself. My eligibility and other information will be explained to me.

**Sign this application.** The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here with your name, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)
-----------	-------------------

## STEP 6

### Mail your signed application to:

MQD/EB-Oahu Section  
P. O. Box 3490  
Honolulu, HI 96811-3490

MQD/EB-Kapolei Unit  
P. O. Box 29920  
Honolulu, HI 96820-2320

MQD/EB-East Hawaii Section  
1404 Kilauea Avenue  
Hilo, HI 96720-4670

MQD/EB-West Hawaii Section  
Lanihau Professional Center  
75-5591 Palani Road, Suite 3004  
Kailua-Kona, HI 96740-3633

MQD/EB-Lanai Unit  
P. O. Box 631374  
Lanai City, HI 96763-0737

MQD/EB-Maui Section  
Millyard Plaza  
210 Imi Kala Street, Suite 101  
Wailuku, HI 96793-1274

MQD/EB-Molokai Unit  
P. O. Box 1619  
Kaunakakai, HI 96748-1619

MQD/EB-Kauai Section  
4473 Pahee Street, Suite A  
Lihue, HI 96766-2037

If you want to register to vote, you can complete the attached voter registration form or download a form from [hawaii.gov/elections](http://hawaii.gov/elections).

**?** **NEED HELP WITH YOUR APPLICATION?** Visit [mybenefits.hawaii.gov](http://mybenefits.hawaii.gov) or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-855-585-8604.

# APPENDIX A

## Health Coverage from Jobs

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

### EMPLOYEE Information

1. Employee name (First, Middle, Last)

2. Employee Social Security number

□□□ - □□ - □□□□

### EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) _____ - _____	
5. Employer address		6. Employer phone number ( ) -	
7. City	8. State	9. ZIP code	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above) ( ) -		12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? \_\_\_\_\_  
(mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: \_\_\_\_\_ Name: \_\_\_\_\_ Name: \_\_\_\_\_

No (Stop here and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs. a. How much would the employee have to pay in premiums for this plan? \$ _____ b. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly

16. What change will the employer make for the new plan year (if known)?

Employer won't offer health coverage.

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.\* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$ \_\_\_\_\_

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

Date of change (mm/dd/yyyy): \_\_\_\_\_

\* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)



# EMPLOYER COVERAGE TOOL

Form Approved  
OMB No. 0938-1191

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

## EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last)

2. Social Security Number

□ □ □ - □ □ - □ □ □ □

## EMPLOYER Information

Ask the employer for this information.

3. Employer name		4. Employer Identification Number (EIN) _____ - _____	
5. Employer address (notice will be sent to this address)		6. Employer phone number (     )     -	
7. City	8. State	9. ZIP code	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above) (     )     -		12. Email address	

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?  
\_\_\_\_\_ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

Yes. Which people?    Spouse    Dependent(s)

No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*? <input type="checkbox"/> Yes (Go to question 15) <input type="checkbox"/> No (STOP and return form to employee)
15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs. a. How much would the employee have to pay in premiums for this plan? \$ _____ b. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

Employer won't offer health coverage.

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.\* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$ \_\_\_\_\_

b. How often?    Weekly    Every 2 weeks    Twice a month    Once a month    Quarterly    Yearly

Date of change (mm/dd/yyyy): \_\_\_\_\_

\* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)



# APPENDIX B

## American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1		AI/AN PERSON 2	
	First	Middle	First	Middle
1. Name (First name, Middle name, Last name)	Last		Last	
2. Member of a federally recognized tribe?	Yes If yes, tribe name  No		Yes If yes, tribe name  No	
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	Yes  No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? Yes No		Yes  No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? Yes No	
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: <ul style="list-style-type: none"> <li>Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties</li> <li>Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)</li> <li>Money from selling things that have cultural significance</li> </ul>	\$ _____ How often? _____		\$ _____ How often? _____	



# APPENDIX C

Form Approved  
OMB No. 0938-1191

## Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, call 1-877-628-5076. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code

7. Phone number

( ) —

8. Organization name

9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature

11. Date (mm/dd/yyyy)

### Authorized Representative:

As the designated Authorized Representative, I agree to maintain the confidentiality of any information provided to me by the Department or its designee and I can be released as the Authorized Representative by signing below:

Signature of Authorized Representative	Telephone	Date	
Street Address	City	State	Zip Code

As applicable, I \_\_\_\_\_, am a provider or staff member or volunteer of an  
PRINT Name of Individual

organization: \_\_\_\_\_  
PRINT Name of Provider / Organization

I understand and agree, as a condition of serving as the Authorized Representative, will adhere to the regulations relating to confidentiality of information and the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf, as well as other relevant State and Federal Laws covering conflicts of interest and confidentiality of information.

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable)







### 3.2. UC-APP-002 Application Intake

#### Screen Flow

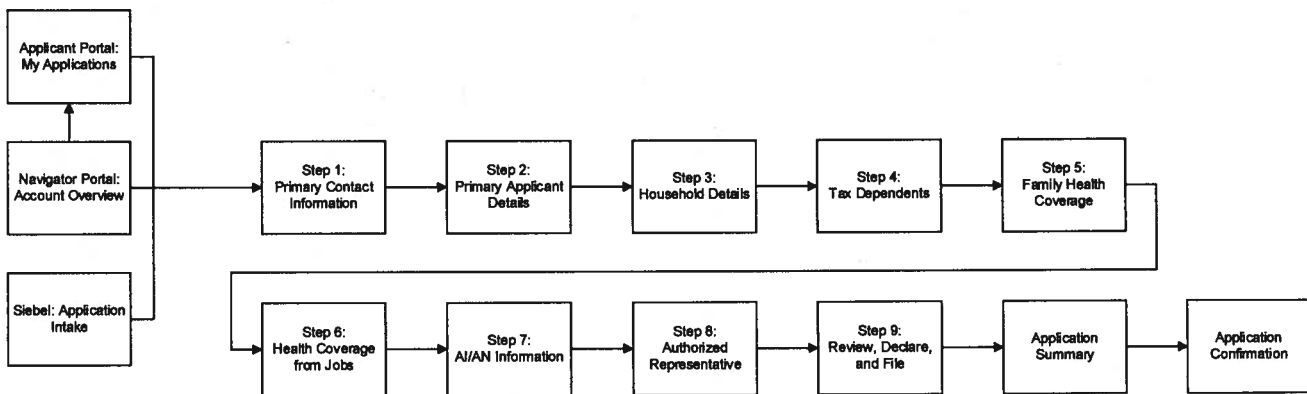


Figure 4 – Application Intake Screen Flow



### Wireframe: Step 1: Primary Contact Information

#### Tell us about yourself.

<b>1. First Name</b> Erin	<b>Middle Name</b> J	<b>Last Name</b> Rashid	<b>Suffix</b> ↓
<b>2. Home address (Leave blank if you don't have one.)</b>			
<b>Line 1</b> 123 Paper St		<b>3. Apartment or suite number</b> 	
<b>4. City</b> Sacramento	<b>5. State</b> CA	<b>6. Zip code</b> 95811	
Please provide a mailing address if different from your home address.			
<b>7. Mailing Address</b>			
<b>Line 1</b> 		<b>8. Apartment or suite number</b> 	
<b>9. City</b> 	<b>10. State</b> ↓	<b>11. Zip code</b> 	
<b>12. Phone number</b> 	<b>13. Other phone number</b> 		
<b>14. Do you want to get information about this application by email?</b> <input type="radio"/> Yes <input checked="" type="radio"/> No			
<b>15. Preferred Spoken Language</b> English ↓		<b>16. Preferred Written Language</b> English ↓	

Figure 5 – Primary Contact Information Wireframe

KOLEA Project – Application Intake Design Specification Document (DSD)  
Version 13.0



## Wireframe: Step 2: Primary Applicant Details

### PERSON 1 (Start with yourself)

Complete this step for yourself, your spouse/partner and children who live with you and/or anyone on your Federal Income Tax Return, if you file one. If you don't file a tax return, remember to still add family members who live with you.

1. First Name \*  Middle Name  Last Name  Suffix

2. Relationship to you ? \*  3. Date of birth (mm/dd/yyyy) \*  4. Sex \*

5. Social Security number (SSN)

6. Do you plan to file a Federal Tax Return next year?

a. Will you file jointly with a spouse?

Name of spouse  First Name  Middle Name  Last Name

b. Will you claim any dependents on your tax return?

Name of dependent  First Name  Middle Name  Last Name

c. Will you be claimed as a dependent on someone's tax return?

Name of tax filer  First Name  Middle Name  Last Name

7. Are you pregnant? \*

How many babies are expected during this pregnancy? \*  Expected Due Date \*

8. Do you need a health coverage?

9. Do you have a physical or psychological health condition that causes limitation in activities? \*

a. Is this a permanent disability? \*

b. Do you currently receive or would you like to receive long term care services?

c. Do you want help paying for medical bills from the last 3 months?

10. Are you a U.S. citizen or U.S. national? \*

11. If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status? \*

a. Are you a citizen of the Federated State of Micronesia, the Republic of Marshall Islands, or Palau?

b. Immigration Document type \*

c. Document ID number \*

d. When did you enter the U.S.?

e. Are you, or your spouse or parent a veteran or an active duty member of the US military?

12. Do you live with at least one child under the age of 18, and you are the main person taking care of this child?

13. Were you at a foster care at age 18 or older in Hawaii?

14. If Hispanic/Latino, ethnicity (OPTIONAL - check all that apply.)

Mexican  Mexican American  Chicano/a

Puerto Rican  Cuban

Other

15. Race (OPTIONAL-check all that apply.)

White  Black/African American  American Indian/Alaskan Native

Asian Indian  Chinese  Filipino

Japanese  Korean  Vietnamese

Other Asian  Native Hawaiian  Guamanian/Chamorro

Samoan  Other Pacific Islander

Other

16. Do you have any medical bills for eligible medical services in the past ten (10) calendar days immediately prior to the date of application?

a. If yes, what dates?

From \*

To \*

Figure 6 – Primary Applicant Details Wireframe (Part 1)



### Current Job & Income Information

Employed       Not Employed       Self Employed

Employer name       Address       Phone number

Wages/tips (before taxes)

Amount(\$)       Frequency    
Average Hours worked       Income Start Date       Income End Date

Add Job

In the past year, did you:

#### OTHER INCOME THIS MONTH

Income Type       Amount(\$)       Frequency    
Income Start Date       Income End Date

Add Income

#### DEDUCTIONS

Type of deduction       Amount(\$)       Frequency    
Deduction Start Date       Deduction End Date

Add Deduction

#### YEARLY INCOME

Total income this year       Total income next year(if different)

Figure 7 – Primary Applicant Details Wireframe (Part 2)



### Wireframe: Step 3: Household Details

First Name	Last Name	Relationship	Sex	Date Of Birth	Controls
Erin	Reshid	Self	Male	06/01/1996	

#### Person 2

Complete this step for yourself, your spouse/partner and children who live with you and/or anyone on your Federal Income Tax Return, if you file one. If you don't file a tax return, remember to still add family members who live with you.

1. First Name \*  Middle Name  Last Name \*  Suffix

2. Relationship to you \*  3. Date of birth (mm/dd/yyyy) \*  4. Sex \*

5. Social Security number (SSN)

6. Does Person 2 plan to file a Federal Tax Return next year?

a. Will Person 2 file jointly with a spouse?

Name of spouse: First Name  Middle Name  Last Name

b. Will Person 2 claim any dependents on their tax return?

Name of dependent: First Name  Middle Name  Last Name

c. Will Person 2 be claimed as a dependent on someone's tax return?

Name of tax filer: First Name  Middle Name  Last Name

How are you related to the tax filer?

6. Does PERSON 2 live at the same address as you?

Home address (Leave blank if you don't have one.)

Line 1 \*  Apartment or suite number

City  State  Zip code

Please provide a mailing address if different from your home address.

Mailing Address

Line 1  Apartment or suite number

City  State  Zip code

7. Is PERSON 2 pregnant? \*

How many babies are expected during this pregnancy? \*  Expected Due Date \*

8. Does PERSON 2 need health coverage?

Figure 8 – Household Details Wireframe (Part 1)



### Current Job & Income Information

Employed       Not Employed       Self Employed

If self-employed, answer the following questions:

Type of work       How much net income (profits once business expenses are paid) will you get paid from this self-employment this month?

#### OTHER INCOME THIS MONTH

Income Type       Amount (\$)       Frequency   
Income Start Date       Income End Date

Add Income

#### DEDUCTIONS

Type of Deduction       Amount (\$)       Frequency   
Deduction Start Date       Deduction End Date

Add Deduction

#### YEARLY INCOME

PERSON 2's total income this year?       PERSON 2's total income next year (if you think it will be different)?

Remove Person

Add Person

Figure 9– Household Details Wireframe (Part 2)



## Wireframe: Step 4: Tax Dependents

### Tax Dependents

Answer these questions for everyone applying for help paying for health insurance.

Does Erin Rashid plan to file a federal income tax return NEXT YEAR?			<input checked="" type="radio"/> Yes <input type="radio"/> No
Will Erin Rashid file jointly with a spouse?			No
Name of spouse			
<input type="checkbox"/>	George	Oscar	Bluth
Will Erin Rashid claim any dependents on their tax return?			No
Name of dependents			
<input type="checkbox"/>	George	Oscar	Bluth
Will Erin Rashid be claimed as a dependent on someone's tax return?			No
Name of tax filer			
<input type="checkbox"/>	George	Oscar	Bluth
<input checked="" type="checkbox"/> Check here if this person is not a part of this household			
How is Erin Rashid related to the tax filer?			Parent
Does George Bluth plan to file a federal income tax return NEXT YEAR?			<input type="radio"/> Yes <input checked="" type="radio"/> No

Figure 10 – Tax Dependents Wireframe

- This screen will be pre-populated with information gathered from Steps 2 and 3.
- The application will pre-populate each of the household member checkbox lists by matching the name provided by the User during Steps 2 and 3.
- It is assumed that if the User's spelling of the name of a spouse, dependent, or tax filer does not match one of the household member(s) names, the System will not be able to pre-populate the checkbox list. The User must select the household member(s) from the list in this scenario.



## Wireframe: Step 5: Family Health Coverage

### Your Family's Health Coverage

Is anyone listed on this application enrolled in health coverage now?

- No. If no, skip to next step.
- Yes. If yes, answer the following questions.

Figure 11 – Family Health Coverage Wireframe (Page Load)

### Your Family's Health Coverage

Is anyone listed on this application enrolled in health coverage now?

- No. If no, skip to next step.
- Yes. If yes, answer the following questions.

Is Erin Rashid enrolled in health coverage now?	<input type="radio"/> Yes	<input type="radio"/> No
Is George Bluth enrolled in health coverage now?	<input type="radio"/> Yes	<input type="radio"/> No

Figure 12 – Family Health Coverage Wireframe (Collapsed)





### Your Family's Health Coverage

Is anyone listed on this application enrolled in health coverage now?

- No. If no, skip to next step.
- Yes. If yes, answer the following questions.

Is Erin Rashid enrolled in health coverage now?  Yes  No

#### Coverage Details

Type of Health Insurance \*

Policy Name

Policy Number

Policy Start Date \*

Policy End Date

Includes medical care?

Yes  No

Includes dental care?

Yes  No

Includes vision care?

Yes  No

Is this a limited-benefit plan (like a school accident policy)?

Yes  No

Add Coverage

#### Coverage Details

Type of Health Insurance \*

Policy Number

Policy Start Date \*

Policy End Date

Includes medical care?

Yes  No

Includes dental care?

Yes  No

Includes vision care?

Yes  No

Is this a limited-benefit plan (like a school accident policy)?

Yes  No

Remove Coverage

Figure 13 – Family Health Coverage Wireframe (Expanded)



## Wireframe: Step 6: Health Coverage from Jobs

### Health Coverage from Jobs

Is anyone listed on this application offered health coverage from a job?

- NO. If no, skip to "Other Health Insurance"
- YES. If yes, answer the following questions.

Figure 14 – Health Coverage from Jobs Wireframe (Page Load)



**Health Coverage from Jobs**

Is anyone listed on this application offered health coverage from a job?

NO. If no, skip to "Other Health Insurance"

YES. If yes, answer the following questions.

Is this a state employee benefit plan?  Yes  No

Employer name	Employer Identification Number (EIN)
	<input type="button" value="Remove Employer"/> <input type="button" value="Add Employer"/>

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job.

Tell us about the job that offers coverage.

**Select Employee**

	First Name	Middle Name	Last Name
<input type="checkbox"/>	Erin	J	Rashid
<input type="checkbox"/>	George	Oscar	Bluth

1. Employer name: Soap LLC

2. Employer identification Number (EIN): 46-123445

3. Employer phone number: 123-456-7890

4. Address Line 1: 123 Paper St

5. Address Line 2:

6. City: Sacramento

7. State: CA

8. Zip code: 95811

9. Who can we contact about employee health coverage at this job? Tyler

10. Phone Number: 123-456-7890

11. Email Address: tdurden@gmail.com

12. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?  Yes  No

12a. If you're in a waiting or probationary period, when can you enroll in coverage?

Who does this job offer coverage to?

	First Name	Middle Name	Last Name
<input type="checkbox"/>	Erin	J	Rashid
<input type="checkbox"/>	George	Oscar	Bluth

Tell us about the health plan offered by this employer.

13. Does the employer offer a health plan that meets the minimum value standard?  Yes  No

14. For the lowest-cost plan that meets the minimum value standard offered only to the employee (don't include family plans): if the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

14a. How much would the employee have to pay in premiums for this plan? \$

14b. How often?

15. What change will the employer make for the new plan year (if known)?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.

a. How much would the employee have to pay in premiums for this plan? \$

b. How often?

Date of change (mm/dd/yyyy):

Figure 15 – Health Coverage from Jobs Wireframe (Expanded)



## Wireframe: Step 7: American Indian/Alaska Native Information

### American Indian or Alaska Native Family Member (AI/AN)

Is anyone listed on this application enrolled in health coverage now?

- No,nobody in my family is American Indian or Alaska Native.
- Yes.If yes,answer the following questions.

Figure 16 – American Indian/Alaska Native (“AI/AN”) Information Wireframe (Page Load)

### American Indian or Alaska Native Family Member (AI/AN)

Is anyone listed on this application enrolled in health coverage now?

- No,nobody in my family is American Indian or Alaska Native.
- Yes.If yes,answer the following questions.

Is Erin Rashid an American Indian or Alaska Native?	<input type="radio"/> Yes <input type="radio"/> No
Is George Bluth an American Indian or Alaska Native?	<input type="radio"/> Yes <input type="radio"/> No

Figure 17 – AI/AN Information Wireframe (Collapsed)



### American Indian or Alaska Native Family Member (AI/AN)

Is anyone listed on this application enrolled in health coverage now?

- No, nobody in my family is American Indian or Alaska Native.  
 Yes. If yes, answer the following questions.

Is Erin Rashid an American Indian or Alaska Native?  Yes  No

Is Erin a member of a Federally recognized Tribe ?

- Yes  No

If yes, give the name of the tribe.

Has Erin ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs.

- Yes  No

Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

- Yes  No

Amount:  How often?

Is George Bluth an American Indian or Alaska Native?  Yes  No

Figure 18 – AI/AN Information Wireframe (Expanded)



## Wireframe: Step 8: Authorized Representative

### Authorized Representative

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, call 1-877-628-5076.

Would you like to include an authorized representative?

- No. I would not like to provide an authorized representative.
- Yes. If yes, answer the following questions.

#### Name

First Name	Last Name
------------	-----------

#### Address

Address Line 1		
Address Line 2		
City	[State] ▾	ZIP Code

#### Phone Number

XXX	XXX	XXXX
-----	-----	------

#### Organization

#### ID Number (if applicable)

--	--

Figure 19 – Authorized Representative Wireframe



## Wireframe: Step 9: Review, Declare, and File

Read & Sign this application.

[Download](#) [Print](#)

- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I know that I must tell the Department of Human Services or the Hawaii Health Connector if anything changes (and is different than) what I wrote on this application. I can visit [myhawaiihs.hawaii.gov](http://myhawaiihs.hawaii.gov) or call 1-877-628-5076 to report any changes. I understand that a change in my information could affect my eligibility for members of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting [www.hhs.gov/ocr/office/ffa](http://www.hhs.gov/ocr/office/ffa)
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed) or residing in a state medical institution.
  - If not, the following applicant(s) are incarcerated or institutionalized.

First Name	Last Name	Incarcerated Date	Release Date
<input type="checkbox"/> Erin	Rashid	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> George	Bluth	<input type="text"/>	<input type="text"/>

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), social security, the Department of Homeland Security and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

**Renewal of coverage in future years**

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Department of Human Services and Hawaii Health Connector to use income data, including information from tax returns. The Department of Human Services or the Hawaii Health Connector will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

5 years (the maximum number of years allowed)

If anyone on this application is eligible for medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency right to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside this home?  Yes  No
- I know I will be asked to cooperate with the agency that collects medical support from absent parents. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

**My right to appeal**

If I think the Department of Human Service or Hawaii Health connector has made a mistake, I can appeal its decision. To appeal means to tell someone at the Department of Human Services or Hawaii Health Connector that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the someone at 1-877-628-5076. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

**Sign this application.**

The person who filled out Step 1 should sign this application. If you're an authorized representative, you may sign here as long as you have provided the information required in Step 8.

I Agree the Terms and Conditions

Primary Applicant First Name	Primary Applicant Last Name
<input type="text" value="Erin"/>	<input type="text" value="Rashid"/>

[Save & Exit](#) [Back](#) [Review](#)

Figure 20 – Review, Declare, and File Wireframe



## Wireframe: Application Summary

The wireframe displays a vertical sequence of eight steps, each with a header bar and a content area:

- STEP 1 Primary Contact Information**: Includes the instruction "Read only version of the intake form".
- STEP 2 Primary Applicant Details**
- STEP 3 Household Details**
- STEP 4 Tax Dependents**
- STEP 5 Family Health Coverage**
- STEP 6 Health Coverage from Jobs**
- STEP 7 American Indian / Alaskan Native Information**
- STEP 8 Review, Declare, and File**

Figure 21 – Application Summary Wireframe





**Wireframe: Application Confirmation**

You have successfully submitted your application, [FIRST NAME LAST NAME]

Your application has been received and will be processed shortly.

Your application confirmation number is: [CONFIRMATION #]

[My Account](#)

Figure 22 – Application Confirmation Wireframe

Revision: MSA-PI-75-3  
August 20, 1974

Attachment 2.6-B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

STANDARDS FOR OPTIONAL STATE SUPPLEMENTARY PAYMENTS

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- I. Aged, blind, and disabled recipients of optional State supplementary payments are eligible for medical assistance as categorically needy under this plan. The payments meet the four conditions specified in 45 CFR 248.2(d), that is, they are:
- A. Regular, in cash, and based on need;
  - B. Available on a Statewide basis;
  - C. Made to reasonable classifications of individuals who, except for the level of their income, would be eligible for an SSI payment, as described in the supplement to this ATTACHMENT; and
  - D. Equal to the difference between income and the financial standard used to determine eligibility for the supplement.
- II. There are variations in the payment levels by political subdivisions.
- No.
- Yes, as described below:

State of HAWAII

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2. The method(s) checked below is used in handling resources in excess of those specified above:

- Excess non-income producing property (except the home) must be disposed of
- Any excess resources render the individual ineligible
- Other, described as follows:

DHEW Trans. No. MCAS 80-18  
Trans. Date Dec 22 1980  
DHEW Approval FEB 09 1981